



Department of Health

Request for Proposals

RFP # - 16336

Independent Evaluation of the New York State Delivery System Reform Incentive Payment Program

Issued: December 29, 2015

DESIGNATED CONTACT:

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies the following designated contact to whom all communications attempting to influence the Department of Health's conduct or decision regarding this procurement must be made.

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PERMISSIBLE SUBJECT MATTER CONTACT:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health identifies the following allowable contact for communications related to the submission of written proposals, written questions, pre-bid questions, and debriefings.

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1.0 CALENDAR OF EVENTS

RFP #16336 - EVALUATION OF THE NEW YORK STATE DELIVERY SYSTEM REFORM INVENTIVE PAYMENT PROGRAM)	
<u>EVENT</u>	<u>DATE</u>
Issuance of Request for Proposals	December 29, 2015
Deadline for Submission of Written Questions	January 13, 2016 5:00 p.m. ET
Responses to Written Questions Posted by DOH	On or About January 29, 2016
Deadline for Submission of Proposals	March 1, 2016 5:00 p.m. ET
<i>Anticipated</i> Contract Start Date	October 1, 2016

2.0 OVERVIEW

Through this Request for Proposals (“RFP”), the New York State (“State”) Department of Health (“DOH”) is seeking competitive proposals from an independent evaluator to provide services as further detailed in [Section 3.0](#) (Scope of Work). It is the Department’s intent to award one (1) contract from this procurement.

2.1 Introductory Background

The Delivery System Reform Incentive Payment (DSRIP) Program is the main mechanism by which New York State (NYS) will implement the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP’s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five years. Up to \$6.42 billion is allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health. DSRIP will provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by achieving the MRT Triple Aim of improving care, improving health and reducing costs. Through DSRIP, the NYS Department of Health (Department) seeks to transform the health care safety net, reduce avoidable hospital use and make improvements in other health and public health measures at the system and state level, and ensure sustainability of delivery system transformation through leveraging managed care payment reform. DSRIP provides incentive payments to reward safety net providers that undertake projects designed to transform systems of care supporting Medicaid beneficiaries and low income, uninsured persons by addressing three key elements: safety net system transformation; appropriate infrastructure; and assuming responsibility for a defined population. Safety net providers participating in DSRIP are referred to as Performing Provider Systems (PPS).

The purpose of this Request for Proposals is to seek proposals from responsible and qualified contractors to conduct a multi-method, comprehensive, statewide independent evaluation in accordance with the DSRIP Special Terms and Conditions (STC). The evaluation will employ quantitative and qualitative methods in order to achieve a robust evaluation of this demonstration program, and will achieve the following goals: 1) assess program effectiveness on a statewide level with respect to the MRT Triple Aim, 2) obtain information on the effectiveness of specific projects and strategies selected and the factors associated with program success and 3) obtain feedback from stakeholders including Department staff, PPS administrators and providers, and Medicaid

beneficiaries served under DSRIP regarding the planning and implementation of the DSRIP program, and on the health care service experience under DSRIP reforms. Evaluation results will be regularly reported to the Department, the PPSs and CMS.

For a full description of the DSRIP program, please refer to the documents at the following links:

DSRIP Special Terms and Conditions:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/special_terms_and_conditions.pdf

Attachment I: Program Funding and Mechanics Protocol:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/program_funding_and_mechanics.pdf

Attachment J: DSRIP Strategies and Metrics Menu:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/strategies_and_metrics_menu.pdf

DSRIP Project Toolkit:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf

DSRIP Measure Specification and Reporting Manual:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_measure_specification_and_reporting_manual_for_public_comment.pdf

2.2 Important Information

The bidder is required to review, and is requested to have legal counsel review, Attachment E, the DOH Agreement as the Bidder must be willing to enter into an Agreement substantially in accordance with the terms of Attachment E should the bidder be selected for contract award. Please note that this RFP and the awarded bidder's proposal will become part of the contract as Appendix B and C, respectively.

It should be noted that Appendix A of Attachment E, "Standard Clauses for New York State Contracts", contains important information related to the contract to be entered into as a result of this RFP and will be incorporated, without change or amendment, into the contract entered into between DOH and the successful Bidder. By submitting a response to the RFP, the Bidder agrees to comply with all the provisions of Appendix A.

Note, Attachment A, the Bidder's Certifications/Acknowledgements, should be submitted and includes a statement that the bidder accepts, without any added conditions, qualifications or exceptions, the contract terms and conditions contained in this RFP including any exhibits and attachments. It also includes a statement that the bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the DOH.

Any qualifications or exceptions proposed by a bidder to this RFP should be submitted in writing using the process set forth in [Section 5.2](#) (Questions) prior to the deadline for submission of written questions indicated in [Section 1.0](#) (Calendar of Events). Any amendments DOH makes to the RFP as a result of questions and answers will be publicized on the DOH web site.

2.3 Term of the Agreement

This contract term is expected to be for a period of five years commencing on the date shown on the Calendar of Events in [Section 1.0](#), subject to the availability of sufficient funding, successful contractor performance, and approvals from the New York State Attorney General (AG) and the Office of the State Comptroller (OSC).

3.0 SCOPE OF WORK

This Section describes the evaluation services that are required to be provided by the selected bidder. Bidder must be able to provide all of these services throughout the contract term.

PLEASE NOTE: Bidders will be required to provide responses that address all of the RFP requirements of this as part of its Technical Proposal.

For purposes of this RFP, the use of the terms “shall”, “must” and “will” are used interchangeably when describing the Contractor’s/Bidder’s duties. The terms bidders, vendors and proposers are also used interchangeably.

3.1 Performance Standards/Expectations

The Independent Evaluator will design and implement a multi-method, robust statewide evaluation of the NYS DSRIP Program consistent with the specifications outlined in STC sections VIII.21 through VIII.33. An evaluation plan drafted by NYS is included as Attachment K to this RFP. This evaluation plan may be adopted in whole or in part, or replaced entirely with an original plan from the Bidder. Proposals submitted in response to this solicitation must demonstrate the ability to fully document the impact of DSRIP on health care service delivery, health improvements and cost to the Medicaid program, as well as to determine program components that were particularly successful or posed significant challenges in terms of DSRIP implementation and outcomes. The evaluation must address the following overarching questions:

1. To what extent did PPSs achieve health care system transformation?
2. Did health care quality improve as a result of clinical improvements in the treatment of selected diseases and conditions?
3. Did population health improve as a result of implementation of the DSRIP initiative?
4. Did utilization of behavioral health care services increase as a result of DSRIP?
5. Was avoidable hospital use reduced as a result of DSRIP?
6. Did DSRIP reduce health care costs?
7. What were the successes and challenges with respect to PPS planning, implementation, operation and plans for program sustainability from the perspectives of DSRIP planners, administrators and providers, and why were they successful and challenging?

Proposals for the DSRIP evaluation must contain the following components:

1. Time series design

As stated in the STCs, quantitative analysis to assess the effect of DSRIP on a statewide level will use a time series approach to the comparison of health outcomes following the implementation of DSRIP, to a time period prior to DSRIP’s implementation. Using this approach, proposals must include analysis for testing the following hypotheses:

1. Health care service delivery will show greater integration.
2. Health care coordination will improve.
3. Primary care utilization will show a greater upward trend.
4. Expenditures for primary care services will increase.
5. Utilization of, and expenditures for, behavioral health care service will increase.
6. Expenditures for emergency department and inpatient services will decrease.
7. Primary care, behavioral health, and dental service utilization will increase among the uninsured, non-utilizing, and low-utilizing populations, while emergency department use will decrease.
8. Through clinical improvements implemented under DSRIP, health care quality in each of the following areas will increase:
 - a. Behavioral health
 - b. Cardiovascular health
 - c. Diabetes care
 - d. Asthma
 - e. HIV/AIDS
 - f. Perinatal care
 - g. Palliative care
 - h. Renal care
9. Population health measures will show improvements in the following 4 areas:
 - a. Mental health and substance abuse
 - b. Prevention of chronic diseases
 - c. Prevention of HIV and STD’s
 - d. Health of women, infants, and children
10. Avoidable hospital use will be reduced.

11. Costs associated with hospital inpatient and ED services will show reductions or slowed growth
12. Total cost of care will show reductions or slowed growth

2. Qualitative analysis

Qualitative information obtained from DSRIP planners, administrators, providers, and beneficiaries is expected to play a vital role in the DSRIP evaluation. Qualitative methods should be incorporated into DSRIP evaluation proposals for two broad purposes:

1. To identify facilitators and barriers to PPS's achieving progress on pay-for-reporting/pay-for-performance metrics using feedback from PPS administrators, providers, and patients, as well as to identify these issues that are characteristic of particular strategies or projects.
2. To conduct PPS case study evaluation by obtaining information from DSRIP stakeholders on an ongoing basis on program planning, implementation, operation, and effectiveness to guide quality improvement through project refinements and enhancements.

Qualitative methods to be used may be key informant interviews, focus groups, and surveys, with issues to be investigated qualitatively to include notable program outcomes and challenges, effectiveness of governance structure and provider linkages, contractual and financial arrangements, changes in the delivery of patient care, the effect of other ongoing health care initiatives (e.g., New York Prevention Agenda, Affordable Care Act) on DSRIP implementation and operation, and patient experience and satisfaction with services. In the qualitative component of the evaluation, proposals should include the development of qualitative instruments to address the central evaluation questions and to augment results of quantitative analysis. This will include the determination of interview or survey questions with appropriate review and pre-testing to ensure that questions are comprehensive, understandable, and reliable, a plan and schedule for data collection, and a plan for analysis.

3. Comparative analysis

To address questions pertaining to the effects of type of projects adopted by PPS's, the relative effectiveness of specific strategies employed within project types, and the contextual factors associated with PPS success or failure to demonstrate improvement in the metrics associated with each domain, quantitative and qualitative comparative analyses should be proposed. Issues to address through quantitative or qualitative comparative analysis may include:

1. Where there is variation in the strategies selected per the PPS project requirements described in the STC documents, assess the effect on the pertinent outcome of PPS's having selected a particular strategy. For example, a comparison would be made in the improvement in diabetes care (Domain 2) between PPS's that implement a project to address this issue and PPS's that do not.
2. The relative effectiveness of particular projects intended to produce the same outcome. For example, among PPS's that opt for a strategy to improve asthma care, compare such improvement between those PPS's that chose to implement a project to expand asthma home-based self-management programs to those PPS's that chose alternative projects to improve asthma care.
3. Identification common to those PPSs receiving or not receiving maximum payment based on project valuation.
4. Comparisons between PPS's operating in different regions of New York to identify successes and challenges associated with local resources or procedures.
5. Patient-level comparisons by factors such as age, sex, race, presence of selected chronic conditions, and mental health/substance abuse status to obtain information on variations in service experience and satisfaction under DSRIP, by patient characteristics.

Measures and Available Data

A set of measures described in the *DSRIP Strategies Menu and Metrics* will be used to quantify facets of system transformation (Domain 2), quality of care through clinical improvements (Domain 3), and population health (Domain 4) using existing data sources, described below. Though bidders are not limited to the use of these measures in their proposed evaluation plans, they may be used for purposes of the DSRIP evaluation in assessing statewide

outcomes. The majority of these measures are well established with known measurement stewards (e.g., 3M, AHRQ), and are commonly used in health care quality improvement activities.

Regardless of outcome measures chosen for the evaluation plan, the selected contractor will have access to a number of existing data sources that are maintained by, or are available to, the New York State Department of Health. Given public health law and/or data use agreements that govern access to these data, bidders for the Independent Evaluator should be aware that obtaining access may require substantial time and effort, which should be considered when developing the evaluation timeline.

Medicaid Claims

This database contains billing records for health care services, including pharmacy, for approximately 5.7 million individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid claims database is updated on a monthly basis to include additional claims and modifications to existing claims. Given the claims processing, there is a 6-month lag in the availability of complete and finalized Medicaid claims data, where data for a given year are considered final by June 30th of the following year.

Medicare Claims

For the approximately 15% of Medicaid enrollees who are dually eligible for Medicare, Medicare claims will be used to ensure data completeness, as many of the services received by this group will be paid by Medicare and thus not appear in the Medicaid database. Medicare claims contains billing records for health care services, including pharmacy services, along with data on diagnoses and provider information. NYSDOH is working with an external entity specializing in the linking of Medicaid and Medicare claims data which will ensure timely access to Medicare claims through monthly data updates.

Statewide Planning and Research Cooperative System (SPARCS)

The Statewide Planning and Research Cooperative System (SPARCS) is an all payer data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for inpatient and outpatient (ambulatory surgery, emergency department, and outpatient services), hospital services and outpatient services from free-standing ambulatory surgery centers. SPARCS data may be used for medical or scientific research or statistical or epidemiological purposes. All entities seeking SPARCS identifiable or limited data must submit a request to SPARCS Operations using standard data request forms. Finalized SPARCS data for a given year are available in August of the following year.

Minimum Data Set (MDS)

MDS 2.0 and 3.0 data consist of federally mandated assessments collected at regular intervals on all nursing home residents in New York. Assessment data collected include diseases and conditions, nutritional status, resident physical and cognitive functioning (e.g., activities of daily living), medications received, and nursing home admission source and discharge disposition. These data have been shown to be adequately reliable and are widely used in research, and are available to the New York Department of Health under data use agreement with CMS. There is, approximately, a 6-month lag in the availability of complete MDS data, where finalized data for a given year are available in June of the following year.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The Clinician & Group version of the CAHPS® survey will be administered by NYSDOH annually during the DSRIP demonstration period and will serve as the data source for selected outcome measures. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and office staff. This includes information on patient experience over the last twelve months including most recent visit to provider, ease of getting an appointment, and wait times while in the office. The survey includes standardized questionnaires for adults and children. The adult questionnaire can be used in both primary care and specialty care settings; the child questionnaire is designed for primary care settings, but could be adapted for specialty care. Users can also add supplemental items to customize their questionnaires. Surveys are administered in September of a given year, and are available for use in February of the following year. Given confidentiality agreements, only de-identified CAHPS data will be available for use.

New York Vital Statistics

Birth and death certificate data are maintained by New York, with New York City Department of Health and Mental Hygiene and the New York Department of Health comprising two separate jurisdictions in the reporting of birth and death records, which will likely necessitate separate data use agreements. NYSDOH has the responsibility for annual statewide reporting of vital statistics governed by the terms of a memorandum of understanding between the two jurisdictions. Birth records contain information such as maternal medical risk factors, prenatal care received, infant birth date, birth weight, and infant diseases/conditions including congenital malformations. Death certificate data include date of death, underlying and multiple cause of death, decedent demographics, county of residence, and county of death. While Vital Statistics data are received by NYSDOH on an ongoing basis, due to the process of updating and finalizing information from birth and death certificates (e.g., due to delayed receipt of lab results), data for a given year are not considered complete until the end of the following year.

Expanded Behavioral Risk Factor Surveillance System (eBRFSS)

The Expanded Risk Factor Surveillance System (eBRFSS) augments the CDC Behavioral Risk Factor Surveillance System (BRFSS), which is conducted annually in New York. eBRFSS is a random-digit-dialed telephone survey among adults 18 years of age and older representative of the non-institutionalized civilian population with landline telephones or cell phones living in New York. The goal of eBRFSS is to collect county-specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. Topics assessed by the eBRFSS include tobacco use, physical inactivity, diet, use of cancer screening services, and other factors linked to the leading causes of morbidity and mortality. The 2013-2014 eBRFSS survey will be used as the baseline for DSRIP for measures derived from these data, and contains a question to identify Medicaid respondents. Repeat eBRFSS surveys to be used in support of the DSRIP evaluation will be conducted in 2016-2017, and again in 2019-2020.

New York HIV/AIDS Case Surveillance Registry

The New York HIV/AIDS Case Surveillance Registry contains information on new cases of HIV and AIDS, as well as persons living with HIV or AIDS. Data include date of diagnosis, HIV exposure category, county of residence at diagnosis, and whether or not diagnosis was made while individual was incarcerated.

Uniform Assessment System (UAS)

The Uniform Assessment System contains assessment data on individuals receiving home or community-based long term care (e.g., adult day health care, long term home health care). Data include patient functional status, health status, cognitive functioning, and care preferences.

US Census

US census data are publicly available from the US Census Bureau, and contain estimates of population size, and data on population characteristics. The latter include housing status, income, employment status, educational level, and health insurance coverage. US census data are gathered on an ongoing basis from a number of surveys including the Decennial Census, the American Community Survey, and the Economic Census.

Medical Record

Measures that are derived from Medical records will be reported by PPSs, or their participating providers.

Medicaid and Medicare Claims

Medicaid and Medicare claims, as well as SPARCS data are available from the OHIP Data Mart. Implemented in 1998, the OHIP Data Mart serves as a data repository to support analytical reporting and applications for the NYSDOH, the Office of the Medicaid Inspector General, and the Office of the Attorney General. It supports analytics and ad hoc user queries, and supports a number of projects including Medicaid Claims History, the Medicaid Drug Rebate Application, and MRT Performance Analytics.

3.2 Tasks/Deliverables

1. **Interim Evaluation Report.** Per agreement between NYSDOH and CMS, this report must contain evaluation results from quantitative and qualitative data available for reporting by due date

Draft Due to NYSDOH for review	February 15, 2019
Draft Interim Evaluation Report due to CMS	March 30, 2019
Final Interim Evaluation Report due to NYSDOH for review	May 15, 2019
Final Interim Evaluation Report due to CMS	June 30, 2019

2. **Summative Evaluation Report.** Per agreement between NYSDOH and CMS, this report must cover the entire five-year demonstration, and contain the major results and conclusions with respect to DSRIP's operation and effectiveness. This will be the final report from the DSRIP evaluation. Content of the report is described in STC Section 25.

Preliminary Summative Evaluation Report due to NYSDOH for review	May 15, 2020
Preliminary Summative Evaluation Report due to CMS	June 30, 2020
Draft of Final Summative Evaluation Report due to NYSDOH for review	November 15, 2020
Final Draft Summative Evaluation Report due to CMS	December 28, 2020
Final Summative Evaluation Report due to NYSDOH for review	February 15, 2021
Final Summative Evaluation Report due to CMS	March 28, 2021

3. **Annual Statewide Reports.** For the first four years of the demonstration, annual summaries of major DSRIP evaluation results to be shared with state policymakers, PPS planners, administrators and providers in order to highlight areas of success and those in need of improvement, and to guide any needed program modifications and enhancements.

Each demonstration year's annual report is due on March 31 of the following year. No annual statewide report is due for DY 5, as it will be replaced by the Summative Evaluation Report.

4. **Annual PPS Reports.** The Contractor will, on an annual basis for each of the five demonstration years, distribute results from interviews and surveys administered on the PPS level back to those PPSs, with the expectation that receipt of information that is specific to their own projects will assist their ongoing quality improvement efforts.

Each demonstration year's PPS report is due on March 31 of the following year.

5. **Meetings with CMS.** The Contractor will, as necessary, participate in meetings/conference calls with CMS pertaining to New York's DSRIP evaluation.

6. **Cooperation with Federal Evaluation.** The Contractor will cooperate with any Federal evaluation activities that may be undertaken by CMS.

3.3 Staffing Requirements

Though there are no specific staffing requirements, the appropriateness of the staffing plan per Section 6.2.E will be considered in the review of proposals.

3.4 Reporting Requirement

Through quarterly reports, Contractor will provide updates to NYSDOH on data collection, analysis, and the status of written products, including activities completed during the quarter, and any difficulties encountered. These reports will be due March 31, June 30, September 30, and December 31 of each contract year.

4.0 BIDDERS QUALIFICATIONS TO PROPOSE

4.1 Minimum Qualifications

NYSDOH will accept proposals from organizations with all of the following types and levels of experience as a prime contractor.

- A minimum of three year's experience conducting large-scale, multi-year program evaluations;
- A designated lead evaluator with at least masters level training in public health, statistics, social sciences or a related field;
- A minimum of three years of experience managing and analyzing data from large, complex data systems;
- A minimum of three years of experience developing qualitative instruments, and in collecting and analyzing qualitative data; and
- Ability for the prime contractor and any proposed subcontractors to act as an independent, unbiased third party in conducting the evaluation in that bidders must not have any business relationship with any of the PPSs or their participating providers.

Contractors for DSRIP support services and the Independent Assessor are not eligible to apply.

For the purposes of this RFP, a prime contractor is defined as one who has the contract with the owner of a project or job and has full responsibility for its completion. A prime contractor undertakes to perform a complete contract and may employ (and manage) one or more subcontractors to carry out specific parts of the contract. Failure to meet these Minimum Qualifications will result in a proposal being found non-responsive and eliminated from consideration.

4.2 Preferred Qualifications

It is preferred that bidders have:

- a designated lead evaluator with doctoral level training in public health, statistics, social sciences, or a related field;
- demonstrated knowledge of the NYS healthcare landscape and DSRIP program;
- demonstrated experience with large and complex data systems, which include Medicaid claims; and
- demonstrated experience in reporting research and evaluation results in the context of their implications for health policy.

Scoring of technical proposals will take into account possession of these preferred qualifications as per Technical Proposal Requirements, Section 6.2.D.

5.0 ADMINISTRATIVE INFORMATION

The following administrative information will apply to this RFP. Failure to comply fully with this information may result in disqualification of your proposal.

5.1 Restricted Period

"Restricted period" means the period of time commencing with the earliest written notice, advertisement, or solicitation of a Request for Proposals ("RFP"), Invitation for Bids ("IFB"), or solicitation of proposals, or any other method for soliciting a response from Bidders intending to result in a procurement contract with DOH and ending with the final contract award and approval by DOH and, where applicable, final contract approval by the Office of the State Comptroller.

This prohibition applies to any oral, written, or electronic communication under circumstances where a reasonable person would infer that the communication was intended to influence this procurement. Violation of any of the requirements described in this Section may be grounds for a determination that the bidder is non-responsive and therefore ineligible for this contract award. Two violations within four years of the rules against impermissible

contacts during the “restricted period” may result in the violator being debarred from participating in DOH procurements for a period of four years.

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies a designated contact on face page of this RFP to whom all communications attempting to influence this procurement must be made.

5.2 Questions

There will be an opportunity available for submission of written questions and requests for clarification with regard to this RFP. All questions and requests for clarification of this RFP should cite the particular RFP Section and paragraph number where applicable and must be submitted via email to:

Michael Lewandowski
New York State Department of Health
Office of Health Insurance Programs
Division of Employee and Program Support
One Commerce Plaza, Rm. 1460
Albany, NY 12237
Phone: (518) 486-5386
Email: OHIPContracts@health.ny.gov

It is the bidder’s responsibility to ensure that email containing written questions and/or requests for clarification is received at the above address no later than the Deadline for Submission of Written Questions as specified in [Section 1.0](#) (Calendar of Events). Questions received after the deadline may **not** be answered.

5.3 Right to Modify RFP

DOH reserves the right to modify any part of this RFP, including but not limited to, the date and time by which proposals must be submitted and received by DOH, at any time prior to the Deadline for Submission of Proposals listed in [Section 1.0](#) (Calendar of Events). Modifications to this RFP shall be made by issuance of amendments and/or addenda.

Prior to the Deadline for Submission of Proposals, any such clarifications or modifications as deemed necessary by DOH will be posted to the DOH website.

If the bidder discovers any ambiguity, conflict, discrepancy, omission, or other error in this RFP, the Bidder shall immediately notify DOH of such error in writing at OHIPContracts@health.ny.gov and request clarification or modification of the document.

If, prior to the Deadline for Submission of Proposals, a bidder fails to notify DOH of a known error or an error that reasonably should have been known, the bidder shall assume the risk of proposing. If awarded the contract, the bidder shall not be entitled to additional compensation by reason of the error or its correction.

5.4 Payment

The contractor shall submit invoices and/or vouchers on a monthly basis to the State's designated payment office:

Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: accountspayable@ogs.ny.gov with a subject field as follows:

Subject: <<Unit ID: 3450433 >> <<Contract #>>

Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

NYS Department of Health
Unit ID 3450433
PO Box 2093
Albany, NY 12220-0093

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epayments@osc.state.ny.us or by telephone at 518-474-6019. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9 must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

Payment of such invoices and/or vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be:

The State will review deliverables submitted by the contractor to the State, accept or reject those deliverables, and provide written comments and notice of deficiencies, if any, to the contractor and will use all reasonable efforts to complete the review in less than 30 days business days. The contractor shall correct the deficiencies cited by the State and resubmit the deliverable for approval within ten (10) business days of receipt of the State's comments, unless an extension is requested in writing by the contractor and approved in writing by the State. The contractor shall respond to all State comments and incorporate such response into its resubmission of the deliverable. Full response by the contractor to the State's comments within ten (10) business days will constitute fulfillment of that deliverable unless the State provides, within ten (10) business days of receipt of the resubmitted deliverable, notice of a continuing deficiency. If notice of a continuing deficiency is given, the State will provide to the contractor a detailed description of the deficiencies that continue. If the contractor fails to meet all criteria within the timeframes mentioned above, the State reserves the right to withhold payment until the State is satisfied that all the deliverables have been achieved as set forth in this Agreement.

As used in this section, the term "continuing deficiency" shall be limited to:

- a. Inadequate resolution, in the reasonable judgment of the State, of the items raised during the previous State review; Related issues which were tied to or created by the method of resolving the previous State comments;
- b. Items which could not be thoroughly tested or reviewed by the State because of an inadequate, incorrect or incomplete deliverable, previously submitted, which was identified as inadequate, incorrect or incomplete by the State's previous written comments; and
- c. Omissions of parts of a deliverable. Such reviews and resubmissions shall not be construed as a waiver of any deliverable or obligation to be performed under this Agreement, nor of any scheduled deliverable date, nor any rights or remedies provided by law or under this Agreement, nor State comment on any deliverable, relieve the Contractor from any obligation or requirement of this Agreement.

In the event the State fails to review and accept or reject a deliverable within thirty (30) business days of receipt, the contractor shall notify the State of the late response and proceed with performance as if acceptance had been received from the State. However, such failure by the State to respond shall not constitute acceptance of the deliverable by the State. If, in such circumstances, the State subsequently requires material changes to the deliverable, the parties shall fairly consider and mutually agree as to the effect of the untimely rejection or acceptance on the delivery or

implementation schedules. In no event shall the contractor be entitled to any price increase due to the need to correct deficient deliverables.

The contractor should deliver drafts of deliverables to the State to facilitate the State's review process. Nothing set forth herein with regard to the formal review process for deliverables shall preclude verbal comments by the State to the contractor or its representatives during that process, and those verbal comments may be provided in addition to the formal process set forth herein.

5.5 Minority & Woman-Owned Business Enterprise Requirements

Pursuant to New York State Executive Law Article 15-A, the New York State Department of Health ("DOH") recognizes its obligation to promote opportunities for maximum feasible participation of certified minority-and women-owned business enterprises and the employment of minority group members and women in the performance of DOH contracts.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" ("Disparity Study"). The report found evidence of statistically significant disparities between the level of participation of minority-and women-owned business enterprises in state procurement contracting versus the number of minority-and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority- and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that DOH establish goals for maximum feasible participation of New York State Certified minority- and women – owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs

For purposes of this solicitation, DOH hereby establishes an overall goal of **30%** for MWBE participation, **15%** for Minority-Owned Business Enterprises ("MBE") participation and **15%** for Women-Owned Business Enterprises ("WBE") participation (based on the current availability of qualified MBEs and WBEs and outreach efforts to certified MWBE firms). A contractor ("Contractor") on the subject contract ("Contract") must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that DOH may withhold payment pending receipt of the required MWBE documentation. For guidance on how DOH will determine "good faith efforts," refer to 5 NYCRR §142.8.

The directory of New York State Certified MWBEs can be viewed at: <https://ny.newnycontracts.com>. The directory is found in the upper right hand side of the webpage under "Search for Certified Firms" and accessed by clicking on the link entitled "MWBE Directory". Engaging with firms found in the directory with like product(s) and/or service(s) is strongly encouraged and all communication efforts and responses should be well documented.

By submitting a bid, a bidder agrees to complete an MWBE Utilization Plan (Attachment F, Form #1) of this RFP. DOH will review the submitted MWBE Utilization Plan. If the plan is not accepted, DOH may issue a notice of deficiency. If a notice of deficiency is issued, Bidder agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt. DOH may disqualify a Bidder as being non-responsive under the following circumstances:

- a) If a Bidder fails to submit a MWBE Utilization Plan;
- b) If a Bidder fails to submit a written remedy to a notice of deficiency;
- c) If a Bidder fails to submit a request for waiver (if applicable); or
- d) If DOH determines that the Bidder has failed to document good-faith efforts;

The Contractor will be required to attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to Contract Award may be made at any time during the term of the Contract to DOH, but must be made no later than prior to the submission of a request for final payment on the Contract.

The Contractor will be required to submit a Contractor's Quarterly M/WBE Contractor Compliance & Payment Report to the DOH, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract.

If the Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding will constitute a breach of Contract and DOH may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

New York State certified Minority- and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this procurement. The listing will be publicly posted on the Department's website for reference by the bidding community. A firm requesting inclusion on this list should send contact information and a copy of its NYS M/WBE certification to OHIPContracts@health.ny.gov before the Deadline for Questions as specified in [Section 1.0](#) (Calendar of Events). Nothing prohibits an M/WBE Vendor from proposing as a prime contractor.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.

5.6 Equal Employment Opportunity (EEO) Reporting

By submission of a bid in response to this solicitation, the Bidder agrees with all of the terms and conditions of Attachment E Appendix A including Clause 12 - Equal Employment Opportunities for Minorities and Women. Additionally, the successful bidder will be required to certify they have an acceptable EEO (Equal Employment Opportunity) policy statement in accordance with Section III of Appendix M in Attachment E.

Further, pursuant to Article 15 of the Executive Law (the "Human Rights Law"), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and sub-contractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

The Contractor is required to ensure that it and any subcontractors awarded a subcontract over \$25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work"), except where the Work is for the beneficial use of the Contractor, undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

To ensure compliance with this Section, the Bidder should submit with the bid or proposal an Equal Employment Opportunity Staffing Plan (Attachment F, Form #4) identifying the anticipated work force to be utilized on the Contract. Additionally, the Bidder should submit a Minority and Women-Owned Business Enterprises and Equal Employment Opportunity Policy Statement (Attachment F, Form # 5), to DOH with their bid or proposal.

5.7 Sales and Compensating Use Tax Certification (Tax Law, § 5-a)

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than \$100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

The successful Bidder must file a properly completed Form ST-220-CA with the Department of Health and Form ST-220-TD with the DTF. These requirements must be met before a contract may take effect. Further information can be found at the New York State Department of Taxation and Finance's website, available through this link: <http://www.tax.ny.gov/pdf/publications/sales/pub223.pdf>. Forms are available through these links:

- ST-220 CA: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf
- ST-220 TD: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf

5.8 Workers' Compensation and Disability Benefits Certifications

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that DOH shall not enter into any contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a contract with DOH, successful Bidders will be required to verify for DOH, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed below. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers' Compensation Board, Bureau of Compliance at (518) 486-6307. Failure to provide verification of either of these types of insurance coverage by the time contracts are ready to be executed will be grounds for disqualification of an otherwise successful Proposal. The successful Bidder must submit the following documentation before a contract may take effect.

ONE of the following forms as Workers' Compensation documentation:

A. Proof of Workers' Compensation Coverage:

1. **Form C-105.2** – Certificate of Workers' Compensation Insurance issued by private insurance carrier (or Form U-26.3 issued by the State Insurance Fund); or
2. **Form SI-12** – Certificate of Workers' Compensation Self-Insurance (or Form GSI-105.2 Certificate of Participation in Workers' Compensation Group Self-Insurance); or
3. **Form CE-200** – Certificate of Attestation of Exemption from New York State Workers' Compensation and/or Disability Benefits Coverage.

B. Proof of Disability Benefits Coverage:

ONE of the following forms as Disability documentation:

1. **Form DB-120.1** – Certificate of Disability Benefits Insurance; or
2. **Form DB-155** – Certificate of Disability Benefits Self-Insurance; or
3. **Form CE-200** – Certificate of Attestation of Exemption from New York State Workers' Compensation and/or Disability Benefits Coverage.

Further information is available at the Workers' Compensation Board's website, which can be accessed through this link: <http://www.wcb.ny.gov>.

5.9 Subcontracting

Bidders may propose use of a subcontractor. The Contractor shall obtain prior written approval from NYSDOH before entering into an agreement for services to be provided by a subcontractor. The Contractor is solely responsible for assuring that the requirements of the RFP are met. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of the prime contract, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the agreement between the DOH and the Contractor. DOH reserves the right to request removal of any Bidder staff or subcontractor's staff if, in DOH's discretion, such staff is not performing in accordance with the Agreement. Subcontractors whose contracts are valued at or above \$100,000 will be required to submit the Vendor Responsibility Questionnaire upon selection of the prime contractor.

5.10 DOH's Reserved Rights

The Department of Health reserves the right to:

1. Reject any or all proposals received in response to the RFP;
2. Withdraw the RFP at any time, at the agency's sole discretion;
3. Make an award under the RFP in whole or in part;
4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP;
5. Seek clarifications and revisions of proposals;
6. Use proposal information obtained through site visits, management interviews and the state's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFP;
7. Prior to the bid opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available;
8. Prior to the bid opening, direct bidders to submit proposal modifications addressing subsequent RFP amendments;
9. Change any of the scheduled dates;
10. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the prospective bidders;
11. Waive any requirements that are not material;
12. Negotiate with the successful bidder within the scope of the RFP in the best interests of the state;
13. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected bidder;
14. Utilize any and all ideas submitted in the proposals received;
15. Every offer shall be firm and not revocable for a period of three hundred and sixty-five days from the bid opening, to the extent not inconsistent with section 2-205 of the uniform commercial code. Subsequent to such three hundred and sixty-five days, any offer is subject to withdrawal communicated in a writing signed by the offerer; and,
16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's proposal and/or to determine an offerer's compliance with the requirements of the solicitation.

5.11 Freedom of Information Law ("FOIL")

All proposals may be disclosed or used by DOH to the extent permitted by law. DOH may disclose a proposal to any person for the purpose of assisting in evaluating the proposal or for any other lawful purpose. All proposals will become State agency records, which will be available to the public in accordance with the Freedom of Information Law. **Any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling, as an exception to the Freedom of Information Law, must be clearly and specifically designated in the proposal as directed in [Section 6.1 \(D\)](#) of the RFP.** If DOH agrees with the

proprietary claim, the designated portion of the proposal will be withheld from public disclosure. Blanket assertions of proprietary material will not be accepted, and failure to specifically designate proprietary material may be deemed a waiver of any right to confidential handling of such material.

5.12 Lobbying

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, made significant changes as it pertains to development of procurement contracts with governmental entities. The changes included:

- a) made the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
- b) required the above mentioned governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;
- c) required governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
- d) authorized the New York State Commission on Public Integrity, (now New York State Joint Commission on Public Ethics), to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
- e) directed the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;
- f) required the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment; (Bidders responding to this RFP should submit a completed and signed [Attachment G](#), "Prior Non-Responsibility Determination".)
- g) increased the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
- h) established the Advisory Council on Procurement Lobbying.

Subsequently, Chapter 14 of the Laws of 2007 amended the Lobbying Act of the Legislative Law, particularly as it related to specific aspects of procurements as follows: (i) prohibiting lobbyists from entering into retainer agreements on the outcome of government grant making or other agreement involving public funding; and (ii) reporting lobbying efforts for grants, loans and other disbursements of public funds over \$15,000.

The most notable, however, was the increased penalties provided under Section 20 of Chapter 14 of the Laws of 2007, which replaced old penalty provisions and the addition of a suspension option for lobbyists engaged in repeated violations. Further amendments to the Lobbying Act were made in Chapter 4 of the Laws of 2010.

Questions regarding the registration and operation of the Lobbying Act should be directed to the New York State Joint Commission on Public Ethics.

5.13 State Finance Law Consultant Disclosure Provisions

In accordance with New York State Finance Law Section 163(4)(g), State agencies must require all contractors, including subcontractors, that provide consulting services for State purposes pursuant to a contract to submit an annual employment report for each such contract.

The successful bidder for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" in order to be eligible for a contract.

The successful winning bidder must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

State Consultant Services Form A: Contractor's Planned Employment and Form B: Contractor's Annual Employment Report may be accessed electronically at: <http://www.osc.state.ny.gov/procurement>.

5.14 Debriefing

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals. Requests must be received no later than ten (10) business days from date of award or non-award announcement.

5.15 Protest Procedures

In the event unsuccessful bidders wish to protest the award resulting from this RFP, bidders should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found in Chapter XI Section 17 of the Guide to Financial Operations (GFO). Available on-line at: <http://www.osc.state.ny.us/agencies/guide/MyWebHelp/>

5.16 Iran Divestment Act

By submitting a bid in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Bidder/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website (currently found at this address: <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>) and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Bidder/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should DOH receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, DOH will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then DOH shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default. DOH reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

5.17 Piggybacking

New York State Finance Law section 163(10)(e) (see also <http://www.ogs.ny.gov/purchase/snt/sflxi.asp>) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

5.18 Encouraging Use of New York Businesses in Contract Performance

Public procurements can drive and improve the State's economic engine through promotion of the use of New

York businesses by its contractors. New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles. All bidders should complete Attachment H, Encouraging Use of New York Businesses in Contract Performance, to indicate their intent to use/not use New York Businesses in the performance of this contract.

6.0 PROPOSAL CONTENT

The following includes the required format and information to be provided by each Bidder. Bidders responding to this RFP must satisfy all requirements stated in this RFP. All Bidders are required to submit complete Administrative, Technical, and Cost proposals. A proposal that is incomplete in any material respect will be rejected.

To expedite review of the proposals, Bidders are required to submit proposals in separate Administrative, Technical, and Cost packages inclusive of all materials as summarized in Attachment B, Proposal Documents. This separation of information will facilitate the review of the material requested. No information beyond that specifically requested is required, and Bidders are requested to keep their submissions to the shortest length consistent with making a complete presentation of qualifications. Evaluations of the Administrative, Technical, and Cost Proposals received in response to this RFP will be conducted separately. Bidders are therefore cautioned not to include any Cost Proposal information in the Technical Proposal documents.

DOH will not be responsible for expenses incurred in preparing and submitting the Administrative, Technical, or Cost Proposals. Such costs should not be included in the Proposal.

6.1 Administrative Proposal

The Administrative Proposal should contain all requirements listed below. A proposal that is incomplete in any material respect may be eliminated from consideration. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP will be subject to verification for accuracy. Please provide the forms in the same order in which they are requested.

A. M/WBE Forms

Submit completed Form #1 and/or Form #2, Form #4 and Form #5 as directed in [Attachment F](#), "Guide to New York State DOH M/WBE RFP Required Forms."

B. Bidder's Disclosure of Prior Non-Responsibility Determinations

Submit a completed and signed [Attachment G](#), "Prior Non-Responsibility Determination".

C. Vendor Responsibility Questionnaire

Complete, certify, and file a **New York State Vendor Responsibility Questionnaire**. DOH recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions at www.osc.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep System online at <https://portal.osc.state.ny.us>.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the OSC Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website, www.osc.state.ny.us/vendrep, or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

Bidder's should complete and submit the Vendor Responsibility Attestation [Attachment J](#).

D. Freedom of Information Law – Proposal Redactions

Bidders must clearly and specifically identify any portion of the proposal that a Bidder believes constitutes proprietary information entitled to confidential handling as an exception to the Freedom of Information Law. See [Section 4.10](#), (Freedom of Information Law).

E. Bidder's Certified Statements

Submit [Attachment A](#), **Bidder's Certified Statements**, which includes information regarding the Bidder. Attachment A must be signed by an individual authorized to bind the Bidder contractually. Please indicate the title or position that the signer holds with the Bidder. DOH reserves the right to reject a proposal that contains an incomplete or unsigned Attachment A or no Attachment A.

F. References

Provide references using [Attachment D](#) (References) for three prior customers, external to the bidder or subcontractor organizations. The purpose is to provide DOH the ability to verify the information contained in the bidder's proposal. Provide firm names, addresses, contact names, telephone numbers, and email addresses.

G. Encouraging Use of New York Business

Submit [Attachment H](#), Encouraging use of New York Business in Contract Performance to indicate which New York Businesses you will use in the performance of this contract.

6.2 Technical Proposal

The purpose of the Technical Proposal is to demonstrate the qualifications, competence, and capacity of the Bidder to perform the services contained in this RFP. The Technical Proposal should demonstrate the qualifications of the Bidder and of the staff to be assigned to provide services related to the services included in this RFP.

A Technical Proposal that is incomplete in any material respect may be eliminated from consideration. The following outlines the required information to be provided, in the following order, by Bidders. The information requested should be provided in the prescribed format. Responses that do not follow the prescribed format may be eliminated from consideration. All responses to the RFP will be subject to verification for accuracy.

While additional data may be presented, the following should be included. Please provide the information in the same order in which it is requested. Your proposal must contain sufficient information to assure DOH of its accuracy. Failure to follow these instructions may result in disqualification.

Cost information must not be included in the Technical Proposal documents.

A. Title Page

Submit a Title Page providing the RFP subject and number; the Bidder's name and address, the name, address, telephone number, and email address of the Bidder's contact person; and the date of the Proposal.

B. Table of Contents

The Table of Contents should clearly identify all material (by section and page number) included in the proposal.

C. Documentation of Bidder's Eligibility Responsive to Section 4.0 of RFP (Three (3) pages maximum)

The Bidder shall submit a narrative as evidence to the satisfaction of the Department that it, and its proposed subcontractors, possesses the necessary experience and qualifications to perform the services required. Bidders should also attest to their ability and the ability of all proposed subcontractors to act as an independent, unbiased third party in conducting the evaluation, that does not and will not have a business relationship with any of the PPSs or their participating providers.

D. Proposed Technology Solution

Not applicable to this procurement.

E. Technical Proposal Requirements:

a. Executive Summary (Two (2) pages maximum)

The Bidder's executive summary should provide a collective understanding of the contents of the proposal, briefly summarize the strengths of the Bidder, key features of the proposed approach to meet the requirements of the RFP and the major benefits offered by the proposal.

b. Organizational Capacity (Five (5) pages maximum)

The Bidder should describe:

1. Its organizational mission and vision and how this contract will fit into the organization's mission and management structure.
2. Its organizational capacity for quantitative data analysis, including resources such as expertise, equipment and software.
3. Its organizational resources for collection and analysis of survey and interview data.
4. Its ability to meet all requirements of this RFP.

c. Qualifications and Experience (Nine (9) pages maximum)

The Bidder should describe its qualifications and experience as follows:

1. Qualifications

Description of Bidder qualifications demonstrating that required minimum qualifications, outlined in RFP Section 4.1, are met, along with a discussion of preferred qualifications, if applicable, outlined in RFP Section 4.2.

2. Quantitative Data Analysis

- i. Analysis of Medicaid claims data and data from other large data systems, including the goals of such analyses, manner of data access and data extraction.
- ii. Statistical analysis relevant to executing the DSRIP evaluation plan, including the types of analyses and software used.
- iii. Experience in ensuring data quality and integrity of results.

3. Qualitative Data Collection and Analysis

- i. Survey development, including the purpose of the surveys and steps taken to ensure reliability of responses.
- ii. Development of focus group and key informant interviews, including the purpose of such interviews and steps taken to ensure that meaningful responses are obtained.
- iii. Qualitative data collection procedures, including the gaining of access to respondents and

- scheduling.
 - iv. Qualitative data analysis, including the methodology employed and any software used.
4. Report Preparation (up to three samples may be attached as an appendix)
- i. Preparation of reports including results of both quantitative and qualitative analysis.
 - ii. Summative reporting of findings of large scale program evaluations or research projects.

Bidders must clearly indicate those areas where a proposed subcontractor is providing the required qualifications and/or experience.

d. Project Narrative/Evaluation Plan (Twenty (20) pages maximum)

The Bidder must provide a plan to evaluate New York State's DSRIP Program that meets the prevailing standards of scientific and academic rigor, as appropriate and feasible to address the questions outlined in RFP Section II, Scope of Work. The plan must include all of the following:

1. A description of the methodological approach to address evaluation questions, including research design and plans for statistical analysis, as well as the rationale for the methods chosen.
2. A discussion of the measures that will be used for each outcome of interest.
3. A plan for data collection.
4. A discussion of anticipated challenges to the implementation of the evaluation and strategies to mitigate those challenges.
5. A detailed timeline for evaluation activities, specifying the time frame for planning (including obtaining Institutional Review Board (IRB) approval as needed), timeframe for obtaining needed data use agreements, start-up and data collection and analysis; including due dates for deliverables

Any proposed methodologies that require the use of protected health information requires that the bidder be HIPAA compliant and able to sign a Business Associate Agreement (Attachment L).

e. Staffing (five (5) pages maximum, not including resumes)

1. Describe the proposed staffing that will adequately meet the project activities and deliverables. The proposed staffing should demonstrate that project staff will have appropriate training and experience in program evaluation, quantitative data analysis using large and complex data systems, survey and interview development, qualitative data collection and analysis, and report preparation. Include description of roles for each staff person, including the lead evaluator.
2. Provide a job description for each position, detailing staff qualifications for the position. Include total hours per week, and estimated hours dedicated to each major task. Where possible, attach a resume for each staff person in an appendix (does not count toward page limit).
3. Describe how internal management will be conducted for this project. Management oversight should be adequate to ensure integrity of products throughout the course of the contract period.

6.3 Cost Proposal

Submit a completed and signed [Attachment C – Cost Proposal](#). The Cost Proposal shall comply with the mandatory format and content requirements as detailed in this document and in Attachment C. Failure to comply with the mandatory format and content requirements may result in disqualification.

The bid price is to cover the cost of furnishing all of the said services, including but not limited to materials, equipment, profit and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.

7.0 PROPOSAL SUBMISSION

A proposal consists of three distinct parts: (1) the Technical Proposal, (2) the Cost Proposal, and (3) the Administrative Proposal. The table below outlines the required format and volume for submission of each part. Proposals should be submitted in all formats as prescribed below

	Electronic Submission	Original	Copies
Administrative Proposal	2 copies in a standard searchable PDF format on a flash drive, with copy/read permissions only.	3 Original Hard Copies	6 Hard Copies
Technical Proposal	2 copies in a standard searchable PDF format on a flash drive, with copy/read permissions only.	3 Original Hard Copies	6 Hard Copies
Cost Proposal	2 copies in a standard searchable PDF format on a flash drive, with copy/read permissions only.	3 Original Hard Copies	6 Hard Copies

1. All hard copy proposal materials should be printed on 8.5" x 11" white paper (two-sided) and **be clearly page numbered on the bottom of each page with appropriate header and footer information.** A type size of eleven (11) points or larger should be used. The Technical Proposal materials should be presented in three-ring binder(s) separate from the sealed Cost Proposal. The sealed Cost Proposal should also be presented in separate three-ring binder(s);
2. Where signatures are required, the proposals designated as originals should have a handwritten signature and be signed in ink.
3. The NYSDOH discourages overly lengthy proposals. Therefore, marketing brochures, user manuals or other materials, beyond that sufficient to present a complete and effective proposal, are not desired. Elaborate artwork or expensive paper is not necessary or desired. In order for the NYSDOH to evaluate proposals fairly and completely, proposals should follow the format described in this RFP to provide all requested information. The Bidder should not repeat information in more than one section of the proposal. If information in one section of the proposal is relevant to a discussion in another section, the Bidder should make specific reference to the other section rather than repeating the information;
4. Audio and/or videotapes are not allowed. Any submitted audio or videotapes will be ignored by the evaluation team; and
5. The complete proposal must be received by the NYSDOH, no later than the Deadline for Submission of Proposals specified in **Section 1.0**, (Calendar of Events). Late bids will not be considered.
6. In the event that a discrepancy is found between the electronic and hardcopy proposal, the original hardcopy will prevail.

Proposals should be submitted in three (3) separate, clearly labeled packages: an Administrative Proposal, a Technical Proposal and a Cost Proposal, prepared in accordance with the requirements stated in this RFP. Flash drives should be submitted with each section, and should only contain electronic copies of documents specific to that section. Mark the outside envelope of each proposal as "RFP# (Name) – (Technical) (Administrative) or (Cost) Proposal submitted by (Bidder's name)". The three sealed proposals may be combined into one mailing, if desired.

Proposals must be submitted, by U.S. Mail, by courier/delivery service (e.g., FedEx, UPS, etc.) or by hand as noted below, in a sealed package to:

Department of Health (RFP # XX-XX)
Attention: Michael Lewandowski
New York State Department of Health
Office of Health Insurance Programs
Division of Employee and Program Support
One Commerce Plaza, Room 1460
Albany, NY 12237

NOTE: You should request a receipt containing the time and date received and the signature of the receiver for all hand-deliveries and ask that this information also be written on the package(s).

Submission of proposals in a manner other than as described in these instructions (e.g., fax, electronic transmission) will not be accepted.

7.1 No Bid Form

Bidders choosing not to bid are requested to complete the No-Bid form [Attachment I](#).

8.0 EVALUATION PROCESS/CRITERIA

8.1 General Information

DOH will evaluate each proposal based on the “Best Value” concept. This means that the proposal that best “optimizes quality, cost, and efficiency among responsive and responsible offerers” shall be selected for award (State Finance Law, Article 11, §163(1)(j)).

DOH at its sole discretion, will determine which proposal(s) best satisfies its requirements. DOH reserves all rights with respect to the award. All proposals deemed to be responsive to the requirements of this procurement will be evaluated and scored for technical qualities and cost. Proposals failing to meet the requirements of this document may be eliminated from consideration. The evaluation process will include separate technical and cost evaluations, and the result of each evaluation shall remain confidential until both evaluations have been completed and a selection of the winning proposal is made.

The evaluation process will be conducted in a comprehensive and impartial manner, as set forth herein, by an Evaluation Committee. The Technical Proposal and compliance with other RFP requirements (other than the Cost Proposal) will be weighted **70%** of a proposal’s total score and the information contained in the Cost Proposal will be weighted **30%** of a proposal’s total score.

Bidders may be requested by DOH to clarify the contents of their proposals. Other than to provide such information as may be requested by DOH, no Bidder will be allowed to alter its proposal or add information after the Deadline for Submission of Proposals listed in [Section 1.0](#) (Calendar of Events),

In the event of a tie, the determining factors for award, in descending order, will be: (1) lowest cost and (2) proposed percentage of MWBE participation.

8.2 Submission Review

DOH will examine all proposals that are received in a proper and timely manner to determine if they meet the proposal submission requirements, as described in [Section 6.0](#) (Proposal Content) and [Section 7.0](#) (Proposal Submission), and include the proper documentation, including all documentation required for the Administrative Proposal, as stated in this RFP. Proposals that are materially deficient in meeting the submission requirements or have omitted material documents, in the sole opinion of DOH, may be rejected.

8.3 Technical Evaluation

The evaluation process will be conducted in a comprehensive and impartial manner. A Technical Evaluation Committee comprised of program staff of DOH will review and evaluate all proposals.

The Technical Evaluation Committee members will independently score each Technical Proposal that meets the submission requirements of this RFP. The individual Committee Member scores will be averaged to calculate the Technical Score for each responsive Bidder.

The technical evaluation is **70%** of the final score.

8.4 Cost Evaluation

The Cost Evaluation Committee will examine the Cost Proposal documents. The Cost Proposals will be opened and reviewed for responsiveness to cost requirements. If a cost proposal is found to be non-responsive, that proposal may not receive a cost score and may be eliminated from consideration.

Each proposal that meets the submission requirements passes the Preliminary Evaluation, and meets the cost proposal requirements will receive a cost score. The Cost Proposals will be scored based on a maximum cost score of 30 points. The maximum cost score will be allocated to the proposal with the lowest all-inclusive not-to-

exceed maximum price. All other responsive proposals will receive a proportionate score based on the relation of their Cost Proposal to the proposals offered at the lowest final cost, using this formula:

$$C = (A/B) * 30\%$$

A is Total price of lowest cost proposal;

B is Total price of cost proposal being scored; and

C is the Cost score.

The cost evaluation is **30%** of the final score.

8.5 Composite Score

A composite score will be calculated by the DOH by adding the preliminary Technical Proposal points and the Cost points awarded. Finalists will be determined based on preliminary composite scores.

8.6 Reference Checks

The Bidder will submit references using [Attachment D](#) (References). At the discretion of the Evaluation Committee, references may be checked at any point during the process.

8.7 Best and Final Offers

NYSDOH reserves the right to request best and final offers. In the event NYSDOH exercises this right, all bidders that submitted a proposal that met the minimum mandatory requirements will be asked to provide a best and final offer. Bidders will be informed that should they choose not to submit a best and final offer, the offer submitted with their proposal will be construed as their best and final offer.

8.8 Award Recommendation

The Evaluation Committee will submit a recommendation for award to the Finalist(s) with the highest composite score(s) whose experience and qualifications have been verified.

The Department will notify the awarded Bidder(s) and Bidders not awarded. The awarded Bidder(s) will enter into a written Agreement substantially in accordance with the terms of **Attachment E**, DOH Agreement, to provide the required services as specified in this RFP. The resultant contract shall not be binding until fully executed and approved by the New York State Office of the Attorney General and the Office of the State Comptroller.

ATTACHMENTS

- A Bidder's Certified Statements
- B Proposal Document Checklist
- C Cost Proposal
- D References
- E DOH Agreement
- F Guide to New York State DOH M/WBE Required Forms & Forms
- G Bidder's Disclosure of Prior Non-Responsibility Determination
- H Encouraging Use of New York Businesses in Contract Performance
- I No-Bid Form
- J Vendor Responsibility Attestation

ATTACHMENT A

BIDDER'S CERTIFIED STATEMENTS

(MANDATORY SUBMISSION: to be completed and included in the Administrative Proposal documents)

RFP #16336 – Evaluation of the New York State Delivery System Reform Incentive Payment Program
1. Information with regard to the Bidder
A. Provide the Bidder's name, address, telephone number, and fax number.
Name: Click here to enter text.
Address: Click here to enter text.
City, State, ZIP Code: Click here to enter text.
Telephone Number (including area code): Click here to enter text.
Fax Number (including area code): Click here to enter text.
B. Provide the name, address, telephone number, and email address of the Bidder's Primary Contact with DOH with regard to this proposal.
Name: Click here to enter text.
Address: Click here to enter text.
City, State, ZIP Code: Click here to enter text.
Telephone Number (including area code): Click here to enter text.
Email Address: Click here to enter text.
2. By submitting the bid the Bidder acknowledges and agrees to all of the following: [Please note: alteration of any language contained in this section may render your proposal non-responsive.]
Bidder certifies that either there is no conflict of interest or that there are business relationships and /or ownership interests for the organization for the above named organization that may represent a conflict of interest for the organization as a bidder and attached to this form is a description of how the potential conflict of interest and/or disclosure of confidential information relating to this contract will be avoided.
The Bidder certifies that it can and will provide and make available, at a minimum, all services as described in the RFP if selected for award.
Bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the DOH.
Bidder accepts, without any added conditions, qualifications or exceptions, the contract terms and conditions contained in this RFP including any exhibits and attachments.
The bidder is either registered to do business in NYS, or if formed or incorporated in another jurisdiction than NYS, can provide a Certificate of Good Standing from the applicable jurisdiction or provide an explanation, subject to the sole satisfaction of the Department, if a Certificate of Good Standing is not available, and if selected, the vendor will register to do business in NYS.

A. The Bidder is (check as applicable):	
<input type="checkbox"/>	A New York State Certified Minority-Owned Business Enterprise
<input type="checkbox"/>	A New York State Certified Woman-Owned Business Enterprise
<input type="checkbox"/>	A New York State Certified Minority and Woman-Owned Business Enterprise (Dual Certified)
<input type="checkbox"/>	None of the above
B. Provide the name, title, address, telephone number, and email address of the person authorized to receive Notices with regard to the contract entered into as a result of this procurement. See Section __ of the DOH Agreement (Attachment E), NOTICES.	
Name:	Click here to enter text.
Title:	Click here to enter text.
Address:	Click here to enter text.
City, State, ZIP Code:	Click here to enter text.
Telephone Number (including area code):	Click here to enter text.
Email Address:	Click here to enter text.
C. Bidder's Taxpayer Identification Number:	
	Click here to enter text.
D. Bidder's NYS Vendor Identification Number as discussed in Section 6.1.F, if enrolled:	
	Click here to enter text.
By my signature on this Attachment A, I certify to the statements made above in Section 2 and that I am authorized to bind the Bidder contractually. Furthermore, I certify that all information provided in connection with its proposal is true and accurate.	

Typed or Printed Name of Authorized Representative of the Bidder	

Title/Position of Authorized Representative of the Bidder	

Signature of Authorized Representative of the Bidder	

Date	

ATTACHMENT B

PROPOSAL DOCUMENT CHECKLIST

Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.

RFP # 16336 – Evaluation of the New York State Delivery System Reform Incentive Payment Program		
FOR THE ADMINISTRATIVE PROPOSAL		
RFP §	REQUIREMENT	INCLUDED
§ 6.1.A	M/WBE Participation Requirements:	<input type="checkbox"/>
	Attachment F Form 1	<input type="checkbox"/>
	Attachment F Form 2 (If Applicable)	<input type="checkbox"/>
§ 6.1.B	Appendix G – Disclosure of Prior Non-Responsibility Determinations, completed and signed.	<input type="checkbox"/>
§ 6.1.C	Attachment J - Vendor Responsibility Questionnaire, online or if hard copy, completed, and signed.	<input type="checkbox"/>
§ 6.1.D	Freedom of Information Law – Proposal Redactions (If Applicable)	<input type="checkbox"/>
§ 6.1.E	Attachment A - Bidder's Certified Statements, completed & signed.	<input type="checkbox"/>
§ 6.1.F	Attachment D (References)	<input type="checkbox"/>
§ 6.1.G	Attachment H - Encouraging Use of New York Businesses in Contract Performance	<input type="checkbox"/>
FOR THE TECHNICAL PROPOSAL		
RFP §	REQUIREMENT	INCLUDED
§ 6.2.A	Title Page	<input type="checkbox"/>
§ 6.2.B	Table of Contents	<input type="checkbox"/>
§ 6.2.C	Documentation of Bidder's Eligibility	<input type="checkbox"/>
§ 6.2.D	Proposed Technology Solution	N/A
§ 6.2.E	1. Executive Summary 2. Organizational Capacity 3. Experience 4. Project Narrative/Evaluation Plan 5. Staffing	<input type="checkbox"/>
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	REQUIREMENT	INCLUDED
§ 6.3	Attachment C- Cost Proposal	<input type="checkbox"/>

ATTACHMENT C

COST PROPOSAL

Bidder's Name: _____

Bidder's Signature: _____

Instructions: For each of the four major deliverables, propose measurable milestones toward the completion of each that will serve as the basis for payment. Examples of milestones include number of informant interviews completed quarterly and price per interview, or progress reports documenting staff time and effort on tasks related to each deliverable. Modify format, as needed, to align with number and type of proposed milestones. Total proposed cost is the sum of the yearly total costs.

Deliverable	Year 1		Year 2		Year 3		Year 4		Year 5	
<i>1 – Annual PPS Reports</i>										
Milestone 1	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 2	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 3	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Total										
<i>2 – Statewide Evaluation Report</i>										
Milestone 1	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 2	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	

Milestone 3	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Total										
<i>3 – Interim Evaluation Report</i>										
Milestone 1	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 2	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 3	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Total										
<i>4 – Summative Evaluation Report</i>										
Milestone 1	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 2	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Milestone 3	Number									
	Price Per		Price Per		Price Per		Price Per		Price Per	
	Total		Total		Total		Total		Total	
Total										
Yearly Total Cost										

TOTAL PROPOSED COST: _____

Deliverable	Year 1	Year 2	Year 3	Year 4	Year 5
<i>1 – Annual PPS Reports</i>					
Milestone 1	Number		Number		Number
<i>3 - Interim Evaluation Report</i>	Price Per			Price Per	
	Total		Total		Total
Milestone 2	Number			Number	
	Price Per			Price Per	
	Total			Total	
Milestone 3	Number			Number	
	Price Per			Price Per	
	Total			Total	
Total					

ATTACHMENT D

REFERENCES

Submit a total of **THREE** references (Section 6.0.F) using this form.
Expand fields and duplicate this page as necessary.

RFP # 16336 – Evaluation of the New York State Delivery System Reform Incentive Payment Program	
BIDDER:	
Provide the following information for each reference submitted. Fields will expand as you type.	
Reference Company #1:	Click here to enter text.
Contact Person:	Click here to enter text.
Address:	Click here to enter text.
City, State, Zip:	Click here to enter text.
Telephone Number:	Click here to enter text.
Email Address:	Click here to enter text.
Number of years Bidder provided services to this entity:	Click here to enter text.
Brief description of the services provided:	Click here to enter text.
Reference Company #2:	Click here to enter text.
Contact Person:	Click here to enter text.
Address:	Click here to enter text.
City, State, Zip:	Click here to enter text.
Telephone Number:	Click here to enter text.
Email Address:	Click here to enter text.
Number of years Bidder provided services to this entity:	Click here to enter text.
Brief description of the services provided:	Click here to enter text.
Reference Company #3:	Click here to enter text.
Contact Person:	Click here to enter text.
Address:	Click here to enter text.
City, State, Zip:	Click here to enter text.
Telephone Number:	Click here to enter text.
Email Address:	Click here to enter text.
Number of years Bidder provided services to this entity:	Click here to enter text.
Brief description of the services provided:	Click here to enter text.

ATTACHMENT E

DOH AGREEMENT

MISCELLANEOUS / CONSULTANT SERVICES

STATE AGENCY (Name and Address):

Department of Health
Corning Tower
Albany, NY 12237

NYS COMPTROLLER'S NUMBER: C#

ORIGINATING AGENCY GLBU: DOH01
DEPARTMENT ID: 3450437

CONTRACTOR (Name and Address):

TYPE OF PROGRAM(S):

CHARITIES REGISTRATION NUMBER:

CONTRACT TERM

FROM:
TO:

CONTRACTOR HAS () HAS NOT () TIMELY
FILED WITH THE ATTORNEY GENERAL'S
CHARITIES BUREAU ALL REQUIRED
PERIODIC OR ANNUAL WRITTEN REPORTS

FUNDING AMOUNT FOR CONTRACT
TERM:

FEDERAL TAX IDENTIFICATION NUMBER:

STATUS:
CONTRACTOR IS () IS NOT () A
SECTARIAN ENTITY

NYS VENDOR IDENTIFICATION NUMBER:

CONTRACTOR IS () IS NOT () A
NOT-FOR-PROFIT ORGANIZATION

MUNICIPALITY NO. (if applicable)

CONTRACTOR IS () IS NOT () A
N Y STATE BUSINESS ENTERPRISE

() IF MARKED HERE, THIS CONTRACT IS RENEWABLE FOR ___ ADDITIONAL ONE-YEAR PERIOD(S) AT
THE SOLE OPTION OF THE STATE AND SUBJECT TO APPROVAL OF THE OFFICE OF THE STATE
COMPTROLLER.

BID OPENING DATE:

APPENDICES ATTACHED AND PART OF THIS AGREEMENT

Precedence shall be given to these documents in the order listed below.

- X APPENDIX A Standard Clauses as required by the Attorney General for all State Contracts.
- X APPENDIX X Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
- APPENDIX Q *Modification of Standard Department of Health Contract Language*
- X STATE OF NEW YORK AGREEMENT
- X APPENDIX D General Specifications
- X APPENDIX B *Request For Proposal (RFP)*
- X APPENDIX C Proposal
- X APPENDIX E-1 Proof of Workers' Compensation Coverage
- X APPENDIX E-2 Proof of Disability Insurance Coverage
- X APPENDIX H Federal Health Insurance Portability and Accountability Act Business Associate Agreement
- X APPENDIX F Information Data Security Requirements
- X APPENDIX G Notices
- X APPENDIX M *Participation by Minority Group Members and Women with respect to State Contracts: Requirements and Procedures*

Contract No.: C#

IN WITNESS THEREOF, the parties hereto have executed or approved this AGREEMENT on the dates below their signatures.

CONTRACTOR

STATE AGENCY

By: _____

By: _____

Printed Name

Printed Name

Title: _____

Title: _____

Date: _____

Date: _____

State Agency Certification:
"In addition to the acceptance of this contract,
I also certify that original copies of this
signature page will be attached to all other
exact copies of this contract."

STATE OF NEW YORK)
)SS.:
County of _____)

On the ____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(Signature and office of the individual taking acknowledgement)

ATTORNEY GENERAL'S SIGNATURE

STATE COMPTROLLER'S SIGNATURE

Title: _____

Title: _____

Date: _____

Date: _____

**APPENDIX A: STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS
REVISED Appendix A dated January 2014**

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

**PLEASE RETAIN THIS DOCUMENT
FOR FUTURE REFERENCE.**

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licensor, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6-a). However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of

this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex (including gender identity or expression), national origin, sexual orientation, military status, age, disability, predisposing genetic characteristics, marital status or domestic violence victim status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within

the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting

agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication

or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES.

In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
Albany, New York 12245
Telephone: 518-292-5100
Fax: 518-292-5884
email: opa@esd.ny.gov

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business
Development
633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbcertification@esd.ny.gov
<https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS.

Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.

To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

26. IRAN DIVESTMENT ACT. By entering into this Agreement, Contractor certifies in accordance with State Finance Law §165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at: <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf> Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended.

Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

During the term of the Contract, should the state agency receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the state agency will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the state agency shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default. The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

APPENDIX X
GLBU: DOH01

Contract Number: _____

Contractor: _____

Amendment Number X-_____

BSC Unit ID: 345<XXXX>

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the STATE), and _____ (hereinafter referred to as the CONTRACTOR), _____ having its mailing address at _____, for amendment of this contract.

This amendment makes the following changes to the contract (check all that apply):

- _____ Modifies the contract period at no additional cost
- _____ Modifies the contract period at additional cost
- _____ Modifies the budget or payment terms
- _____ Modifies the work plan or deliverables
- _____ Replaces appendix(es) _____ with the attached appendix(es) _____
- _____ Adds the attached appendix(es) _____
- _____ Other: (describe) _____

This amendment *is* / *is not* a contract renewal as allowed for in the existing contract.

All other provisions of said AGREEMENT shall remain in full force and effect.

Additionally, Contractor certifies that it is not included on the prohibited entities list published at <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf> as a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Contractor (or any assignee) also certifies that it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list.

Prior to this amendment, the contract value and period were:

\$ _____ From ____/____/____ to ____/____/____.
(Value before amendment) (Initial start date)

This amendment provides the following modification (complete only items being modified):

\$ _____ From ____/____/____ to ____/____/____.

This will result in new contract terms of:

\$ _____ From ____/____/____ to ____/____/____.
(All years thus far combined) (Initial start date) (Amendment end date)

Signature Page for:

Contract Number: _____

Contractor: _____

Amendment Number: X-_____

BSC Unit ID: 345<XXXX>_____

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By: _____ Date: _____
(signature)

Printed Name: _____

Title: _____

STATE OF NEW YORK)
) SS:
County of _____)

On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

By: _____ Date: _____
(signature)

Printed Name: _____

Title: _____

ATTORNEY GENERAL'S SIGNATURE

By: _____ Date: _____

STATE COMPTROLLER'S SIGNATURE

By: _____ Date: _____

STATE OF NEW YORK
AGREEMENT

This AGREEMENT is hereby made by and between the State of New York Department of Health (STATE) and the public or private agency (CONTRACTOR) identified on the face page hereof.

WITNESSETH:

WHEREAS, the STATE has formally requested contractors to submit bid proposals for the project described in Appendix B for which bids were opened on the date noted on the face pages of this AGREEMENT; and

WHEREAS, the STATE has determined that the CONTRACTOR is the successful bidder, and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor and equipment in connection therewith;

NOW THEREFORE, in consideration of the terms hereinafter mentioned and also the covenants and obligations moving to each party hereto from the other, the parties hereto do hereby agree as follows:

I. Conditions of Agreement

- A. This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.
- B. The maximum compensation for the contract term of this AGREEMENT shall not exceed the amount specified on the face page hereof.
- C. This AGREEMENT may be renewed for additional periods (PERIOD), as specified on the face page hereof.
- D. To exercise any renewal option of this AGREEMENT, the parties shall prepare new appendices, to the extent that any require modification, and a Modification Agreement (the attached Appendix X is the blank form to be used). Any terms of this AGREEMENT not modified shall remain in effect for each PERIOD of the AGREEMENT. The modification agreement is subject to the approval of the Office of the State Comptroller.
- E. Appendix A (Standard Clauses as required by the Attorney General for all State contracts) takes precedence over all other parts of the AGREEMENT.
- F. For the purposes of this AGREEMENT, the terms "Request for Proposals" and "RFP" include all Appendix B documents as marked on the face page hereof.
- G. For the purposes of this AGREEMENT, the term "Proposal" includes all Appendix C documents as marked on the face page hereof.

II. Payment and Reporting

- A. The CONTRACTOR shall submit complete and accurate invoices and/or vouchers, together with supporting documentation required by the contract, the State Agency and the State Comptroller, to the STATE's designated payment office in order to receive payment to one of the following addresses:
 - 1. Preferred Method: Email a .pdf copy of your signed voucher to the BSC at: accountspayable@ogs.ny.gov with a subject field as follows:
Subject: <<Unit ID: 3450437>> <<Contract #>>

(Note: **do not** send a paper copy in addition to your emailed voucher.)

2. Alternate Method: Mail vouchers to BSC at the following U.S. postal address:

**NYS Department of Health
Unit ID 3450437
PO Box 2117
Albany, NY 12220-0117**

- B. Payment of such invoices and/or vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law.

Payment for invoices and/or vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.ny.gov/epay/index.htm, by email at helpdesk@sfs.ny.gov or by telephone at 1-855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any invoices and/or vouchers submitted under this Contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.ny.gov/vendors/vendorguide/guide.htm>.

III. Term of Contract

- A. Upon approval of the Commissioner of Health, this AGREEMENT shall be effective for the term as specified on the cover page.
- B. This Agreement may be terminated by mutual written agreement of the contracting parties.
- C. This Agreement may be terminated by the Department for cause upon the failure of the Contractor to comply with the terms and conditions of this Agreement, including the attachments hereto, provided that the Department shall give the contractor written notice via registered or certified mail, return receipt requested, or shall deliver same by hand-receiving Contractor's receipt therefor, such written notice to specify the Contractor's failure and the termination of this Agreement. Termination shall be effective ten (10) business days from receipt of such notice, established by the receipt returned to the Department. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination.
- D. This Agreement may be deemed terminated immediately at the option of the Department upon the filing of a petition in bankruptcy or insolvency, by or against the Contractor. Such termination shall be immediate and complete, without termination costs or further obligations by the Department to the Contractor.

- E. This agreement may be canceled at any time by the Department of Health giving to the contractor not less than thirty (30) days written notice that on or after a date therein specified this agreement shall be deemed terminated and canceled.

IV. Proof of Coverage

Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:

- A. Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:

1. CE-200, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
2. C-105.2 – Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the U-26.3; OR
3. SI-12 – Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance.

- B. Disability Benefits coverage, for which one of the following is incorporated into this contract as Appendix E-2:

1. CE-200, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
2. DB-120.1 – Certificate of Disability Benefits Insurance OR
3. DB-155 – Certificate of Disability Benefits Self-Insurance

V. Indemnification

- A. The CONTRACTOR shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the CONTRACTOR or its subcontractors pursuant to this AGREEMENT. The CONTRACTOR shall indemnify and hold harmless the STATE and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT.
- B. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the STATE nor make any claims, demand or application to or for any right based upon any different status.

APPENDIX D GENERAL SPECIFICATIONS

- A. By signing the "Bid Form" each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that all specifications, general and specific appendices, including Appendix-A, the Standard Clauses for all New York State contracts, and all schedules and forms contained herein will become part of any contract entered, resulting from the Request for Proposal. Anything which is not expressly set forth in the specifications, appendices and forms and resultant contract, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.
- B. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, e-mail, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.
- C. The Department reserves the right to stop the work covered by this proposal and the contract at any time that the Department deems the successful bidder to be unable or incapable of performing the work to the satisfaction of the Department, and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable, and if the cost thereof exceeds the amount of the bid, the successful bidder and its surety shall be liable to the State of New York for any excess cost on account thereof.
- D. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work to be performed and the conditions under which the contract is to be executed.
- E. The Department of Health will make no allowance or concession to a bidder for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.
- F. The bid price is to cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.
- G. The successful bidder will be required to complete the entire work or any part thereof as the case may be, to the satisfaction of the Department of Health in strict accordance with the specifications and pursuant to a contract therefore.
- H. CONTRACTOR will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.
- I. Non-Collusive Bidding By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief:
 - a. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;
 - b. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition;
 - c. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the state or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (a), (b) and (c) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (a), (b) and (c) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the state, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition. The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

- J. A bidder may be disqualified from receiving awards if such bidder or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
- K. The Department reserves the right to make awards within ninety (90) days after the date of the bid opening, during which period bids shall not be withdrawn unless the bidder distinctly states in the bid that acceptance thereof must be made within a shorter specified time.
- L. Any contract entered into resultant from this request for proposal will be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed for use in the application software provided to the Department as a part of this contract.
- M. Technology Purchases Notification --The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology"
 - 1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.
 - 2. If this RFP results in procurement of software over \$20,000, or of other technology over \$50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO AWARD SELECTION, this RFP and all responses thereto are subject to review by the New York State Office for Technology.
 - 3. Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.

N. Date/Time Warranty

- 1. Definitions: For the purposes of this warranty, the following definitions apply:

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- a. "Product" shall include, without limitation: when solicited from a vendor in a State government entity's contracts, RFPs, IFBs, or mini-bids, any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g., consulting, systems integration, code or data conversion or data entry, the term "Product" shall include resulting deliverables.
- b. "Third Party Product" shall include product manufactured or developed by a corporate entity independent from the vendor and provided by the vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. "Third Party Product" does not include product where vendor is : (a) a corporate subsidiary or affiliate of the third party manufacturer/developer; and/or (b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Date/Time Warranty Statement

CONTRACTOR warrants that Product(s) furnished pursuant to this Contract shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations. Where a CONTRACTOR proposes or an acquisition requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

Where CONTRACTOR is providing ongoing services, including but not limited to: i) consulting, integration, code or data conversion, ii) maintenance or support services, iii) data entry or processing, or iv) contract administration services (e.g., billing, invoicing, claim processing), CONTRACTOR warrants that services shall be provided in an accurate and timely manner without interruption, failure or error due to the inaccuracy of CONTRACTOR's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. CONTRACTOR shall be responsible for damages resulting from any delays, errors or untimely performance resulting therefrom, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of this contract through: a) ninety (90) days or b) the CONTRACTOR's or Product manufacturer/developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under this Contract for breach of warranty.

- O. No Subcontracting: Subcontracting by the CONTRACTOR shall not be permitted except by prior written approval of the Department of Health. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.
- P. Superintendence by Contractor: The CONTRACTOR shall have a representative to provide supervision of the work which CONTRACTOR employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Department when so requested from the CONTRACTOR.
- Q. Sufficiency of Personnel and Equipment: If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the CONTRACTOR to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.
- R. Experience Requirements: The CONTRACTOR shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The CONTRACTOR shall submit at least two references to substantiate these qualifications.

- S. Contract Amendments: This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally.

The CONTRACTOR shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

T. Provisions Upon Default

1. In the event that the CONTRACTOR, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the CONTRACTOR.
2. If, in the judgment of the Department of Health, the CONTRACTOR acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the CONTRACTOR. In such case the CONTRACTOR shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller, have been satisfactorily performed by the CONTRACTOR up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the CONTRACTOR was engaged in at the time of such termination, subject to audit by the State Comptroller.

U. Upon termination of this agreement, the following shall occur:

1. CONTRACTOR shall make available to the State for examination all data, records and reports relating to this Contract; and
2. Except as otherwise provided in the Contract, the liability of the State for payments to the CONTRACTOR and the liability of the CONTRACTOR for services hereunder shall cease.

- V. Conflicts If, in the opinion of the Department of Health, (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the CONTRACTOR shall be deemed to have based his bid upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department of Health will furnish the CONTRACTOR supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.

W. Contract Insurance Requirements

1. The successful bidder must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this proposal and the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this proposal and the contract, whether performed by it or by subcontractors. Before commencing the work, the successful bidder shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to the Department. The kinds and amounts of required insurance are:
 - a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).

- b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than \$500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than \$1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than \$500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than \$1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.
 - i. CONTRACTOR's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.
 - ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.
 - iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

X. Certification Regarding Debarment and Suspension: Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1. APPENDIX B TO PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

- a. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
- b. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
- c. The prospective lower tier participant shall provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
- d. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered Transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules

- implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
- e. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
 - f. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.
 - g. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of parties Excluded from Federal Procurement and Non-procurement Programs.
 - h. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
 - i. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
2. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions
 - a. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily exclude from participation in this transaction by any Federal department agency.
 - b. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Y. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.
2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.
4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.
5. The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.

Z. Provision Related to Consultant Disclosure Legislation

1. If this contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:
 - a. The NYS Department of Health, at the following address New York State Department of Health, Bureau of Contracts Room -2756, Corning Tower, Albany, NY 12237 ; and
 - b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting -or via fax at (518) 474-8030 or (518) 473-8808; and
 - c. The NYS Department of Civil Service, Albany NY 12239, ATTN: Consultant Reporting.

AA. Provisions Related to New York State Procurement Lobbying Law: The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

BB. Provisions Related to New York State Information Security Breach and Notification Act: CONTRACTOR shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). CONTRACTOR shall be liable for the costs associated with such breach if caused by CONTRACTOR'S negligent or willful acts or omissions, or the negligent or willful acts or omissions of CONTRACTOR'S agents, officers, employees or subcontractors.

CC. Lead Guidelines: All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.

DD. On-Going Responsibility

1. General Responsibility Language: The CONTRACTOR shall at all times during the Contract term remain responsible. The CONTRACTOR agrees, if requested by the Commissioner of Health or his or her designee, to present evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.
2. Suspension of Work (for Non-Responsibility) :The Commissioner of Health or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Contract, at any time, when he or she discovers information that calls into question the responsibility of the CONTRACTOR. In the event of such suspension, the CONTRACTOR will be given written notice outlining the particulars of such suspension. Upon issuance of such notice, the CONTRACTOR must comply with the terms of the suspension

order. Contract activity may resume at such time as the Commissioner of Health or his or her designee issues a written notice authorizing a resumption of performance under the Contract.

3. Termination (for Non-Responsibility) : Upon written notice to the CONTRACTOR, and a reasonable opportunity to be heard with appropriate Department of Health officials or staff, the Contract may be terminated by Commissioner of Health or his or her designee at the CONTRACTOR's expense where the CONTRACTOR is determined by the Commissioner of Health or his or her designee to be non-responsible. In such event, the Commissioner of Health or his or her designee may complete the contractual requirements in any manner he or she may deem advisable and pursue available legal or equitable remedies for breach.

EE. Provisions Related to Iran Divestment Act: As a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York, a provision has been added to the State Finance Law (SFL), § 165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) has developed a list (prohibited entities list) of “persons” who are engaged in “investment activities in Iran” (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list has been posted on the OGS website at <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>.

By entering into this Contract, CONTRACTOR (or any assignee) certifies that it will not utilize on such Contract any subcontractor that is identified on the prohibited entities list. Additionally, CONTRACTOR agrees that should it seek to renew or extend the Contract, it will be required to certify at the time the Contract is renewed or extended that it is not included on the prohibited entities list. CONTRACTOR also agrees that any proposed Assignee of the Contract will be required to certify that it is not on the prohibited entities list before the New York State Department of Health may approve a request for Assignment of Contract. During the term of the Contract, should New York State Department of Health receive information that a person is in violation of the above referenced certification, New York State Department of Health will offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment which is in violation of the Act within 90 days after the determination of such violation, then New York State Department of Health shall take such action as may be appropriate including, but not limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the CONTRACTOR in default.

New York State Department of Health reserves the right to reject any request for assignment for an entity that appears on the prohibited entities list prior to the award of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the prohibited entities list after contract award.

APPENDIX B: REQUEST FOR PROPOSAL

To be added upon award

APPENDIX C: PROPOSAL OF BIDDER

To be added upon award.

APPENDIX H: HIPAA CONFIDENTIALITY

for CONTRACTOR that creates, receives, maintains or transmits individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

- I. Definitions. For purposes of this Appendix H of this AGREEMENT:
 - A. “Business Associate” shall mean CONTRACTOR.
 - B. “Covered Program” shall mean the STATE.
 - C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and implementing regulations, including those at 45 CFR Parts 160 and 164.
- II. Obligations and Activities of Business Associate:
 - A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.
 - B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT and to comply with the security standards for the protection of electronic protected health information in 45 CFR Part 164, Subpart C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.
 - C. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:
 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
 5. Contact procedures for Covered Program to ask questions or learn additional information.
 - D. Business Associate agrees, in accordance with 45 CFR § 164.502(e)(1)(ii), to ensure that any Subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of the Business Associate agree to the same

restrictions and conditions that apply to Business Associate with respect to such information.

- E. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.
 - F. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.
 - G. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528; and Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.
 - H. Business Associate agrees, to the extent the Business Associate is to carry out Covered Program's obligation under 45 CFR Part 164, Subpart E, to comply with the requirements of 45 CFR Part 164, Subpart E that apply to Covered Program in the performance of such obligation.
 - I. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- III. Permitted Uses and Disclosures by Business Associate
- A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.
 - B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.
 - C. Business Associate may disclose Protected Health Information as Required By Law.
- IV. Term and Termination
- A. This AGREEMENT shall be effective for the term as specified on the cover page of this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Appendix H of this AGREEMENT.
 - B. Termination for Cause. Upon Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for

Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.

C. Effect of Termination.

1. Except as provided in paragraph (c)(2) below, upon termination of this AGREEMENT, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Program, or created or received by Business Associate on behalf of Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of Business Associate and Covered Program that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this AGREEMENT to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

V. Violations

- A. Any violation of this AGREEMENT may cause irreparable harm to the STATE. Therefore, the STATE may seek any legal remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.
- B. Business Associate shall indemnify and hold the STATE harmless against all claims and costs resulting from acts/omissions of Business Associate in connection with Business Associate's obligations under this AGREEMENT. Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the STATE from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law § 208, caused by any intentional act or negligence of Business Associate, its agents, employees, partners or subcontractors, without limitation; provided, however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

VI. Miscellaneous

- A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.
- B. Amendment. Business Associate and Covered Program agree to take such action as is necessary to amend this AGREEMENT from time to time as is necessary for Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and 164.

- C. Survival. The respective rights and obligations of Business Associate under (IV)(C) of this Appendix H of this AGREEMENT shall survive the termination of this AGREEMENT.
- D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

APPENDIX F
New York State Department of Health
Information Data Security Requirements

A. General Requirements

Contractor agrees that it shall perform the requirements of the contract in a manner consistent with the following requirements:

1. Maintain all Department Data and implement procedures to physically and logically segregate Department's Data from Contractor's data and data belonging to Contractor's other customers.
2. Establish and maintain appropriate environmental, safety and facility procedures, data security procedures and other safeguards against the destruction, corruption, loss or alteration of any Department Data, and to prevent unauthorized access, alteration or interference by third parties of the same.
3. Utilize industry best practices and technology (including appropriate firewall protection, intrusion prevention tools, and intrusion detection tools) to protect, safeguard, and secure the Department Data against unauthorized access, use, and disclosure. Contractor shall constantly monitor for any attempted unauthorized access to, or use or disclosure of, any of such materials and shall immediately take all necessary and appropriate action in the event any such attempt is discovered, promptly notifying the Department of any material or significant breach of security with respect to any such materials.

B. Data Location and Related Restrictions

All Data shall remain in the Continental United States (CONUS). Any Data stored, or acted upon, must be located solely in Data Centers in CONUS. Services which directly or indirectly access Data may only be performed from locations within CONUS.

C. Contractor portable devices

Contractor shall not place Data on any portable Device unless Device is located and remains within Contractor's CONUS Data Center.

D. Data breach - Required Contractor Actions

Unless otherwise provided by law, in the event of a Data Breach, the Contractor shall:

1. Notify the Department or their designated contact person(s), by telephone as soon as possible.
2. Consult with and receive authorization from the Department as to the content of any notice to affected parties prior to notifying any affected parties to whom notice of the Data Breach is required, either by statute or by the Department;
3. Coordinate all communication regarding the Data Breach with the Department;
4. Cooperate with the Department in attempting (a) to determine the scope and cause of the breach; and (b) to prevent the future recurrence of such data breaches; and
5. Take corrective action in the timeframe required by the Department. If Contractor is unable complete the corrective action within the required timeframe the Department may contract with a third party to provide the required services until corrective actions and services resume in a

manner acceptable to the Department, or until the Department has completed a new procurement for a replacement service system. The Contractor will be responsible for the cost of these services during this period. Nothing herein shall in any way (a) impair the authority of the OAG to bring an action against Contractor to enforce the provisions of the New York State Information Security Breach Notification Act (ISBNA) or (b) limit Contractor's liability for any violations of the ISBNA or any other applicable statutes, rules or regulations.

E. Data Ownership

All Department Data is, or will be and shall remain the property of the Department and shall be deemed Confidential Information of the Department. Without the Department's approval Department Data shall not be (1) used by the Contractor or Contractor's Agents other than in connection with providing the Services, (2) disclosed, sold, assigned, leased, or otherwise provided to third parties by Contractor or Contractor's Agents, or (3) commercially exploited by or on behalf of Contractor or Contractor Agents.

F. Contractor Access to Data

The Contractor shall not copy or transfer Data unless authorized by the Department. In such an event the Data shall be copied and/or transferred in accordance with the provisions of this Section. Contractor shall not access any Data for any purpose other than fulfilling the service. Contractor is prohibited from Data Mining, cross tabulating, monitoring Department's Data usage and/or access, or performing any other Data Analytics other than those required under this contract. At no time shall any Data or processes (e.g. workflow, applications, etc.), which either are owned or used by the Department be copied, disclosed, or retained by the Contractor or any party related to the Contractor. Contractors are allowed to perform industry standard back-ups of Data. Documentation of back-up must be provided to the Department upon request.

G. Requests for data by third parties

Unless prohibited by law, Contractor shall notify the Department in Writing within 24 hours of any request for Data (including requestor, nature of Data requested and timeframe of response) by a person or entity other than the Department, and the Contractor shall secure Written acknowledgement of such notification from the Department before responding to the request for Data. Unless compelled by law, the Contractor shall not release Data without the Department's prior written approval.

H. Transfer of Data at end of Contract

At the end of the Contract, Contractor may be required to transfer Data to a new Contractor and/or to the Department. This transfer must be carried out as specified by the Department. This transfer may include, but is not limited to, conversion of all Data into or from an industry standard format(s) including comma/delimited files, txt files, or Microsoft standard file formats.

I. Return of Data

Upon expiration or termination of this Contract, the Contractor shall return Data in a format required by the Department. When requested by the Department, the Contractor must certify that all Data has been removed from its system/s and removed from backups.

J. Secure Data Disposal Certification

If requested by the Department, the Contractor shall destroy Data in all of its forms, including all backups. Data shall be permanently deleted and shall not be recoverable, according to New York State Information Technology Standard Number NYS- S13-003 Sanitization/Secure Disposal or successor and Standard Number NYS-S14-003 Information Security Controls or successor. Certificates of destruction, in a form acceptable to the Department, shall be provided by the Contractor to the Department.

K. Destruction of Data

The Data, and/or the storage medium containing the Data, shall be destroyed in accordance with applicable New York State Information Technology Standard for destruction (Standard Number NYS-S13-003 Sanitization/Secure Disposal and Standard Number NYS-S14-003 Information Security Controls or successor) when the Contractor is no longer contractually required to store and maintain the Data.

L. Background Checks

The Department may require the Contractor to conduct background checks on certain Contractor staff who has access to Department data at no charge to the Department.

M. Separation of Duties

The Department may require the separation of job duties, and limit staff knowledge of Data to that which is absolutely needed to perform job duties.

N. Business continuity/disaster recovery operations

The Contractor shall provide a business continuity and disaster recovery plan if required by the Department.

O. Compliance with federal, state and local regulations

The Department may require the Contractor to provide verification of compliance with specific Federal, State and local regulations, laws and IT standards that the Department is required to comply with.

P. Ownership/title to project deliverables

The Department will be the sole owner of all deliverables furnished under this Contract by or through Contractor including, but not limited to: a) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings), whether printed in hard copy or maintained on diskette, CD, DVD or other electronic media; and b) source code or any software that is developed for use in the application software provided to the Department. Effective upon creation of any deliverable, Contractor hereby conveys, assigns and transfers to the Department the sole and exclusive rights, title and interest in deliverable, whether preliminary, final or otherwise, including all trademark and copyrights.

**APPENDIX G:
NOTICES**

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

- (a) via certified or registered United States mail, return receipt requested;
- (b) by facsimile transmission;
- (c) by personal delivery;
- (d) by expedited delivery service; or
- (e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health

Name:

Title:

Address:

Telephone Number:

Facsimile Number:

E-Mail Address:

[Insert Contractor Name]

Name:

Title:

Address:

Telephone Number:

Facsimile Number:

E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

APPENDIX M PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS: REQUIREMENTS AND PROCEDURES

I. General Provisions

- A. The New York State Department of Health is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 (“MWBE Regulations”) for all State contracts as defined therein, with a value (1) in excess of \$25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of \$100,000 for real property renovations and construction.
- B. The Contractor to the subject contract (the “Contractor” and the “Contract,” respectively) agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State New York State Department of Health (the “New York State Department of Health”), to fully comply and cooperate with the New York State Department of Health in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women (“EEO”) and contracting opportunities for certified minority and women-owned business enterprises (“MWBEs”). Contractor’s demonstration of “good faith efforts” pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the “Human Rights Law”) or other applicable federal, state or local laws.
- C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to Section VII of this Appendix or enforcement proceedings as allowed by the Contract.

II. Contract Goals

- A. For purposes of this Amendment X-?, the New York State Department of Health hereby establishes an overall goal of **30%** for Minority and Women-Owned Business Enterprises (“MWBE”) participation, **15%** for Minority-Owned Business Enterprises (“MBE”) participation and **15%** for Women-Owned Business Enterprises (“WBE”) participation (based on the current availability of qualified MBEs and WBEs).
- B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in Section II-A hereof, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address:
<http://www.esd.ny.gov/mwbe.html>

Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on the Contract.

- C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document “good faith efforts” to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with Section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and

intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the New York State Department of Health for liquidated or other appropriate damages, as set forth herein.

III. Equal Employment Opportunity (EEO)

- A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.
- B. Contractor shall comply with the following provisions of Article 15-A:
 - 1. Contractor and Subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
 - 2. The Contractor shall submit an EEO policy statement to the New York State Department of Health within seventy two (72) hours after the date of the notice by New York State Department of Health to award the Contract to the Contractor.
 - 3. If Contractor or Subcontractor does not have an existing EEO policy statement, the New York State Department of Health may provide the Contractor or Subcontractor a model statement (see Form #5 - Minority and Women-Owned Business Enterprises Equal Employment Opportunity Policy Statement).
 - 4. The Contractor's EEO policy statement shall include the following language:
 - a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
 - b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.
 - c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
 - d. The Contractor will include the provisions of Subdivisions (a) through (c) of this Subsection 4 and Paragraph "E" of this Section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.
- C. Form #4 - Staffing Plan

To ensure compliance with this Section, the Contractor shall submit a staffing plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. Contractors shall complete the Staffing plan form and submit it as part of their bid or proposal or within a reasonable time, but no later than the time of award of the contract.

D. Form #6 - Workforce Employment Utilization Report (“Workforce Report”)

1. Once a contract has been awarded and during the term of Contract, Contractor is responsible for updating and providing notice to the New York State Department of Health of any changes to the previously submitted Staffing Plan. This information is to be submitted on a quarterly basis during the term of the contract to report the actual workforce utilized in the performance of the contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
2. Separate forms shall be completed by Contractor and any subcontractor performing work on the Contract.
3. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Workforce Report and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the contract.

E. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

IV. MWBE Utilization Plan

- A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan (Form #1) either prior to, or at the time of, the execution of the contract.
- B. Contractor agrees to use such MWBE Utilization Plan for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in Section III-A of this Appendix.
- C. Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, New York State Department of Health shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

V. Waivers

- A. For Waiver Requests Contractor should use Form #2 – Waiver Request.

- B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the waiver request is complete, the New York State Department of Health shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.
- C. If the New York State Department of Health, upon review of the MWBE Utilization Plan and updated Quarterly MWBE Contractor Compliance Reports determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the New York State Department of Health may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VI. Quarterly MWBE Contractor Compliance Report

Contractor is required to submit a Quarterly MWBE Contractor Compliance Report (Form #3) to the New York State Department of Health by the 10th day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract.

VII. Liquidated Damages - MWBE Participation

- A. Where New York State Department of Health determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, Contractor shall be obligated to pay to the New York State Department of Health liquidated damages.
- B. Such liquidated damages shall be calculated as an amount equaling the difference between:
 - 1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
 - 2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.
- C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the New York State Department of Health, Contractor shall pay such liquidated damages to the New York State Department of Health within sixty (60) days after they are assessed by the New York State Department of Health unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development pursuant to Subdivision 8 of Section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the New York State Department of Health.

ATTACHMENT F

NEW YORK STATE DOH MWBE RFP REQUIRED FORMS

All DOH procurements have a section entitled “**MINORITY AND WOMEN OWNED BUSINESS ENTERPRISE REQUIREMENTS.**” This section of procurement sets forth the established DOH goal for that particular procurement and also describes the forms that must be completed with their bid. Below is a summary of the forms used in the DOH MWBE Participation Program by a bidder.

Form #1: Bidder MWBE Utilization Plan - This document should be completed by all bidders responding to RFPs with an MWBE goal greater than zero. The bidder must demonstrate how it plans to meet the stated MWBE goal. In completing this form, the bidder should describe the steps taken to establish communication with MWBE firms and identify current or future relationships with certified MWBE firms. The second page of the form should list the MWBE certified firms that the vendor plans to engage with on the project and the amount that each certified firm is projected to be paid. Plans to work with uncertified firms or women and minority staffed firms do not meet the criteria for participation. The firm must be owned and operated by a Woman and/or Minority and must be certified by NYS Empire State Development to be eligible for participation. If the plan is not submitted or is deemed deficient, the bidder may be sent a notice of deficiency. It is mandatory that all awards with goals have a utilization plan on file.

Form #2: MWBE Utilization Waiver Request - This document should be filled out by the bidder if the utilization plan (Form #1) indicates less than the stated participation goal for the procurement. In this instance, Form #2 must accompany Form #1 with the bid. If Form #2 is provided and goal was initially set higher, revised goal approval will be necessary from DOB. When completing Form #2, it is important that the bidder thoroughly document the steps that were taken to meet the goal and provide evidence in the form of attachments to the document. The required attachments are listed on Form #2 and will document the good-faith efforts taken to meet the desired goal. A bidder can also attach additional evidence outside of those referenced attachments. Without evidence of good-faith efforts, in the form of attachments or other documentation, the Department of Health may not approve the waiver and the bidder may be deemed non-responsive.

New MWBE firms are being certified daily and new MWBE firms may now be available to provide products or services that were historically unavailable. If Form #2 is found by DOH to be deficient, the bidder may be sent a deficiency letter which will require a revised form to be returned within 7 business days of receipt to avoid a finding of non-compliance. DOH may work directly with firm to resolve minor deficiencies via e-mail.

Form #3: Replaced by Online Compliance System - <https://ny.newnycontracts.com> Contractors will need to login and submit payments to MWBE Firms in this online system once payments to these vendors commence.

Form #4 – MWBE Staffing Plan- This form should be completed based on the composition of staff working on the project. Enter the numbers or counts in the corresponding boxes and add up the totals in each column. This form is for diversity research purposes only and has no bearing on MWBE goal achievement.

Form #5 – EEO and MWBE Policy Statement -This is a standard EEO policy that needs to be signed and dated and submitted. If Bidder has their own EEO policy it may be submitted instead of endorsing this document.

**New York State Department of Health
M/WBE UTILIZATION PLAN**

Bidder/Contractor Name: Click here to enter text.	
Vendor ID: Click here to enter text.	Telephone No. Click here to enter text. Email: Click here to enter text.
RFP/Contract Title: Click here to enter text.	RFP/Contract No. Click here to enter text.

Description of Plan to Meet M/WBE Goals

Click here to enter text.

PROJECTED M/WBE USAGE

	%	Amount
1. Total Dollar Value of Proposal Bid	100	Click here to enter text.
2. MBE Goal Applied to the Contract	Click here to enter text.	\$ Click here to enter text.
3. WBE Goal Applied to the Contract	Click here to enter text.	\$ Click here to enter text.
4. M/WBE Combined Totals	Click here to enter text.	\$ Click here to enter text.

“Making false representation or including information evidencing a lack of good faith as part of, or in conjunction with, the submission of a Utilization Plan is prohibited by law and may result in penalties including, but not limited to, termination of a contract for cause, loss of eligibility to submit future bids, and/or withholding of payments. Firms that do not perform commercially useful functions may not be counted toward MWBE utilization.”

**New York State Department of Health
M/WBE UTILIZATION PLAN**

MINORITY OWNED BUSINESS ENTERPRISE (MBE) INFORMATION

In order to achieve the MBE Goals, bidder expects to subcontract with New York State certified MINORITY-OWNED entities as follows:

MBE Firm (Exactly as Registered)	Description of Work (Products/Services) [MBE]	Projected MBE Dollar Amount
Name Address City, State, ZIP Employer I.D. Telephone Number () -		\$ _____
Name Address City, State, ZIP Employer I.D. Telephone Number () -		\$ _____
Name Address City, State, ZIP Employer I.D. Telephone Number () -		\$ _____

**New York State Department of Health
M/WBE UTILIZATION PLAN**

WOMEN OWNED BUSINESS ENTERPRISE (WBE) INFORMATION

In order to achieve the WBE Goals, bidder expects to subcontract with New York State certified WOMEN-OWNED entities as follows:

WBE Firm (Exactly as Registered)	Description of Work (Products/Services) [WBE]	Projected WBE Dollar Amount
Name Address City, State, ZIP Employer I.D. Telephone Number () -		\$ _____
Name Address City, State, ZIP Employer I.D. Telephone Number () -		\$ _____
Name Address City, State, ZIP Employer I.D. Telephone Number () -		\$ _____

**New York State Department of Health
Waiver Request**

Offeror/Contractor Name: Click here to enter text.		Federal Identification No.: Click here to enter number.	
Address: Click here to enter text.		Solicitation/Contract No.: Click here to enter number.	
City, State, Zip Code: Click here to enter text.		M/WBE Goal: MBE %%% WBE %%% (From Form #1)	
By submitting this form and the required information, the officer or/contractor certifies that every Good Faith Effort has been taken to promote M/WBE participation pursuant to the M/WBE requirements set forth under the contract.			
Contractor is requesting a: <input type="checkbox"/> MBE Waiver – A waiver of the MBE Goal for this procurement is requested. Total Partial <input type="checkbox"/> WBE Waiver – A waiver of the WBE Goal for this procurement is requested. Total Partial <input type="checkbox"/> Waiver Pending ESD Certification – (Check here if subcontractors or suppliers of Contractor are not certified M/WBE, but an application for certification has been filed with Empire State Development.) Date of such filing with Empire State Development: Click here to enter a date.			
<hr/> PREPARED BY (Signature) _____ Date: _____ SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR/CONTRACTOR'S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A AND 5 NYCRR PART 143. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FINDING OF NONCOMPLIANCE AND/OR TERMINATION OF THE CONTRACT.			
Name and Title of Preparer (Printed or Typed):		Telephone Number:	Email Address:
Submit with the bid or proposal or if submitting after award submit to: doh.sm.mwbe@health.ny.gov		***** FOR DMWBD USE ONLY *****	
		REVIEWED BY:	DATE:
		Waiver Granted: <input type="checkbox"/> YES <input type="checkbox"/> NO MBE: <input type="checkbox"/> WBE: <input type="checkbox"/> <input type="checkbox"/> Total Waiver <input type="checkbox"/> Partial Waiver <input type="checkbox"/> ESD Certification Waiver <input type="checkbox"/> *Conditional <input type="checkbox"/> Notice of Deficiency Issued	
		*Comments:	

- MWBE Form #4 -

New York State Department of Health MWBE STAFFING PLAN

For project staff, consultants and/or subcontractors working on this grant complete the following plan. This has no impact on MWBE utilization goals, or the submitted Utilization Plan - Form#1. This is for diversity research purposes.

Contractor Name _____

Address _____

STAFF	Total	Male	Female	Black	Hispanic	Asian/ Pacific Islander	Other
Executive/Senior level Officials							
Managers/Supervisors							
Professionals							
Technicians							
Administrative Support							
Craft/Maintenance Workers							
Laborers and Helpers							
Service Workers							
Totals							

(Name and Title)

(Signature)

Date

MINORITY AND WOMEN-OWNED BUSINESS ENTERPRISES – EQUAL EMPLOYMENT OPPORTUNITY POLICY STATEMENT

M/WBE AND EEO POLICY STATEMENT

I, _____, the (awardee/contractor) _____ agree to adopt the following policies with respect to the project being developed or services rendered at _____

M/WBE This organization will and will cause its contractors and subcontractors to take good faith actions to achieve the M/WBE contract participations goals set by the State for that area in which the State-funded project is located, by taking the following steps:

Actively and affirmatively solicit bids for contracts and subcontracts from qualified State certified MBEs or WBEs, including solicitations to M/WBE contractor associations. Request a list of State-certified M/WBEs from AGENCY and solicit bids from them directly.

Ensure that plans, specifications, request for proposals and other documents used to secure bids will be made available in sufficient time for review by prospective M/WBEs.

Where feasible, divide the work into smaller portions to enhanced participations by M/WBEs and encourage the formation of joint venture and other partnerships among M/WBE contractors to enhance their participation.

Document and maintain records of bid solicitation, including those to M/WBEs and the results thereof. Contractor will also maintain records of actions that its subcontractors have taken toward meeting M/WBE contract participation goals.

Ensure that progress payments to M/WBEs are made on a timely basis so that undue financial hardship is avoided, and that bonding and other credit requirements are waived or appropriate alternatives developed to encourage M/WBE participation.

EEO (a) This organization will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing programs of affirmative action to ensure that minority group members are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on state contracts.

(b) This organization shall state in all solicitation or advertisements for employees that in the performance of the State contract all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex disability or marital status.

(c) At the request of the contracting agency, this organization shall request each employment agency, labor union, or authorized representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of this organization’s obligations herein.

(d) Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

(e) This organization will include the provisions of sections (a) through (d) of this agreement in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the State contract.

Name & Title

Signature & Date

Detailed Instructions for Completing MWBE Forms 1 & 2

Form#1 – MWBE Utilization Plan

Page #1 of Form #1:

Description of Plan - Describe any steps/details that support Bidder/Contractor plan to meet the MWBE goals stated in the procurement/contract.

Line#1 - Total Dollar Value of Proposal Bid – This line should represent the total dollar amount of bid. The total value is eligible for MWBE goal setting.

Line#2 - MBE Goal Applied to the Contract– Bidder/Contractor lists the amount to be paid/subcontracted to Certified Minority-owned Business Enterprise(s) and the percentage this amount represents of the Total Dollar Value of Proposal Bid listed on Line #1.

Example: If paying two MBE firms \$100,000 & \$50,000 each and Total Dollar Value of Proposal Bid listed on line #1 is \$1,000,000, list 15% and \$150,000 on Line #2.

Line#3 - WBE Goal Applied to the Contract– Bidder/Contractor lists the amount paid/subcontracted to Certified Woman-owned Business Enterprise(s) and the percentage this amount represents of the Total Dollar Value of Proposal Bid listed on Line 1 of the “Form #1 MWBE Utilization Plan”.

Example: If Bidder/Contractor is paying two WBE firms \$50,000 & \$100,000 each and the Total Dollar Value of Proposal Bid listed on line#1 is \$1,000,000 Bidder/Contractor would list 15% and \$150,000 on Line #2 of the Utilization Plan.

Line#4 - MWBE Combined Totals – Total of Line #2 and Line #3. [Line #2 + Line #3 = MWBE Combined Totals]

Example: Using the above Line #2 and Line #3 examples for payment data, Bidder/Contractor achieves a combined MWBE % of 30% and a combined MWBE dollar amount of \$300,000. (15%M and 15%W; \$150,000M + \$150,000W). MWBE total/Total dollar value of bid = %.

Page#2 of Form#1:

The first column (left column): Bidder/Contractor lists any Minority-owned Business Enterprises (MBE) that Bidder/Contractor will be subcontracting with or purchasing from and the MBE contact/company information.

The second column (center column): Bidder/Contractor describes what type of work certified MBE will be providing or what product certified MBE will be supplying to Bidder/Contractor.

Third column (right column): Bidder/Contractor states the amount to be paid to the certified MBE during the term of the contract. The amount totaled from Page #2 should equal the amount listed on Line #2 of Page #1.

Page#3 of Form#1:

The first column (left column): Bidder/Contractor lists any Woman-owned Business Enterprises (WBE) that Bidder/Contractor will be subcontracting with or purchasing from and WBE contact/company information.

The second column (center column): Bidder/Contractor describes what type of work certified WBE will be providing or what product certified WBE will be supplying to Bidder/Contractor.

Third column (right column): Bidder/Contractor states the amount to be paid to the certified WBE during the term of the contract. The amount totaled from Page#3 should equal the amount listed on Line#3 of Page#1.

Form#2 – MWBE Waiver Request

“Form#1 MWBE Utilization Plans” that commit to a goal % less than the stated MWBE goal percentage in procurement, must be accompanied by a “Form#2 MWBE Waiver Request”.

A Bidder/Contractor may qualify for a partial or total waiver of the MWBE goal requirements established on a State contract only upon the submission of a waiver form by a Bidder/Contractor, documenting good-faith efforts by the Contractor to meet the goal requirements of the state contract and a consideration of applicable factors. The ability to subcontract with M/WBEs and separately the ability to purchase with M/WBEs must be addressed in attachments on all waiver requests.

Fill out the header with the name of the Bidder/Contractor requesting the waiver under Offeror/Contractor Name, include your Federal Identification ID, Address, Solicitation/Contract Number, and M/WBE Goals.

Check off the appropriate box for the type of waiver that is being requested and whether it is a total or partial waiver. If the waiver is Pending ESD Certification, meaning the subcontractor has applied for certification with Empire State Development, check off that box and state the date that they applied for certification.

Next, and directly below the Pending ESD Certification area, please sign and date the waiver. Provide the name of the preparer as well as a telephone number and email address (Bidder/Contractor direct contact number of person authorized to discuss submission).

The following attachments should also be provided:

1. A statement setting forth your basis for requesting a partial or total waiver. The statement should at a minimum include the services being subcontracted out and why a portion of those services cannot be subcontracted to Certified MWBE(s). In addition, statement must also include what purchases of equipment and supplies are being made and why those purchases cannot be provided by certified MWBE(s).
2. The names of general circulation, trade association, and M/WBE-oriented publications in which you solicited certified M/WBEs for the purposes of complying with your participation goals related to this contract.
3. A list identifying the date(s) that all solicitations for certified M/WBE participation were published in any of the above publications.
4. A list of all certified M/WBEs appearing in the NYS Directory of Certified Firms that were solicited for purposes of complying with your certified M/WBE participation levels.
5. Copies of notices, dates of contact, letters, and other correspondence as proof that solicitations were made in writing and copies of such solicitations, or a sample copy of the solicitation if an identical solicitation was made to all certified M/WBEs.

6. Provide copies of responses to your solicitations received by you from certified M/WBEs.
7. Provide a description of any contract documents, plans, or specifications made available to certified M/WBEs for purposes of soliciting their bids and the date and manner in which these documents were made available.
8. Provide documentation of any negotiations between you, the Offeror/Contractor, and the M/WBEs undertaken for purposes of complying with the certified M/WBE participation goals.
9. Provide any other information you deem relevant which may help us in evaluating your request for a waiver.

*** All attachments are created by the entity requesting the waiver. These are self-generated attachments and are not provided by the agency.**

ATTACHMENT G

BIDDER’S DISCLOSURE OF PRIOR NON-RESPONSIBILITY DETERMINATIONS

Procurement Title:[Type text]
RFP #: [Type text]
Bidder Name: [Type text]
Bidder Address: [Type text]

Bidder SFS Vendor ID #: [Type text]
Bidder Federal ID#: [Type text]

Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller (“restricted period”) to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document*. DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: <http://ogs.ny.gov/acpl/>

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please check):

No Yes

If yes, please answer the next questions:

1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please check):

No Yes

1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

No Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity: [Type text]

Date of Finding of Non-responsibility: [Type text]

Basis of Finding of Non-Responsibility: [Type text]

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No Yes

2b. If yes, please provide details below.

Governmental Entity: [Type text]

Date of Termination or Withholding of Contract: [Type text]

Basis of Termination or Withholding: [Type text]

(Add additional pages as necessary)

Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

(Officer Signature)

(Date)

(Officer Title)

(Telephone)

(e-mail Address)

ATTACHMENT H

ENCOURAGING USE OF NEW YORK BUSINESSES IN CONTRACT PERFORMANCE

I. Background

New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles.

Bidders/proposers need to be aware that all authorized users of this contract will be strongly encouraged, to the maximum extent practical and consistent with legal requirements, to use responsible and responsive New York State businesses in purchasing commodities that are of equal quality and functionality and in utilizing service and technology. Furthermore, bidders/proposers are reminded that they must continue to utilize small, minority and women-owned businesses, consistent with current State law.

Utilizing New York State businesses in State contracts will help create more private sector jobs, rebuild New York's infrastructure, and maximize economic activity to the mutual benefit of the contractor and its New York State business partners. New York State businesses will promote the contractor's optimal performance under the contract, thereby fully benefiting the public sector programs that are supported by associated procurements.

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its contractors. The State therefore expects bidders/proposers to provide maximum assistance to New York businesses in their use of the contract. The potential participation by all kinds of New York businesses will deliver great value to the State and its taxpayers.

II. Required Identifying Information

Bidders/proposers can demonstrate their commitment to the use of New York State businesses by responding to the question below:

Will New York State Businesses be used in the performance of this contract?

YES NO

If yes, identify New York State businesses that will be used and attach identifying information. Information should include at a minimum: verifiable business name, New York address and business contact information.

New York Business Identifying Information Business Name	Business Address	Contact Name	Contact Phone	Contact Email Address

ATTACHMENT I

NO-BID FORM

PROCUREMENT TITLE: _____ RFP # _____

Bidders choosing not to bid are requested to complete the portion of the form below:

- We do not provide the requested services. Please remove our firm from your mailing list
- We are unable to bid at this time because:

- Please retain our firm on your mailing list.

(Firm Name)

(Officer Signature)

(Date)

(Officer Title)

(Telephone)

(e-mail Address)

FAILURE TO RESPOND TO BID INVITATIONS MAY RESULT IN YOUR FIRM BEING REMOVED FROM OUR MAILING LIST FOR THIS SERVICE.

ATTACHMENT J

VENDOR RESPONSIBILITY ATTESTATION

To comply with the Vendor Responsibility Requirements outlined in Section E, Administrative, 8. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

- An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: <https://portal.osc.state.ny.us> within the last six months.

- A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.

- A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

ATTACHMENT K

New York DSRIP Evaluation Plan Framework

The Delivery System Reform Incentive Program (DSRIP), a component of the New York Medicaid Redesign Team (MRT) Waiver Amendment, is to provide incentives for Medicaid providers to create and sustain an integrated, high performing health care delivery system that can effectively and efficiently meet the needs of Medicaid beneficiaries and low income uninsured individuals in their local communities by achieving the Triple Aim of improving care, improving health, and reducing costs. Through DSRIP, the New York Department of Health seeks to transform the health care safety net, reduce avoidable hospital use and make improvement in other health and public health measures at the system and state level, and ensure sustainability of delivery system transformation through leveraging managed care payment reform. DSRIP funds provide incentive payments to reward safety net providers that undertake projects designed to transform systems of care supporting Medicaid beneficiaries and the low income uninsured by addressing three key elements: safety net system transformation; appropriate infrastructure; and assuming responsibility for a defined population. Safety net providers participating in DSRIP are referred to as Performing Provider Systems (PPS). The DSRIP Special Terms and Conditions (STC), the governing agreement between New York and CMS of Partnership Plan 1115 Waiver, Attachment I: Program Funding and Mechanics Protocol, and Attachment J: Strategies and Metrics Menu can be accessed at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/cms_official_docs.htm.

New York will conduct a multi-method, comprehensive statewide evaluation to document the impact of DSRIP on health care service delivery, health improvements, and cost to the Medicaid program, as well as to determine program components that posed particular successes or challenges for implementation and outcomes. The multi-method approach involves quantitative, qualitative, and comparative analytic methods in order to achieve a robust evaluation of this demonstration program. The broad goals of the New York DSRIP evaluation are to 1) assess program effectiveness on a statewide level with respect to the MRT Triple Aim of improved care, better health, and reduced cost, 2) conduct comparative analyses at the PPS level to obtain information on the effectiveness of specific projects and strategies selected and the factors associated with program success, and 3) obtain feedback from stakeholders including New York Department of Health staff, PPS administrators and providers, and Medicaid beneficiaries served under DSRIP regarding the planning and implementation of the DSRIP program and, and on the health care service experience under DSRIP reforms. Toward these goals, the following questions will be addressed:

8. To what extent did PPS's achieve health care system transformation?
9. Did health care quality improve as a result of clinical improvements in the treatment of selected diseases and conditions?
10. Did population health improve as a result of implementation of the DSRIP initiative?
11. Did utilization of behavioral health care services increase as a result of DSRIP?
12. Was avoidable hospital use reduced as a result of DSRIP?
13. Did DSRIP reduce health care costs?
14. What were the successes and challenges with respect to PPS planning, implementation, operation, and plans for program sustainability from the perspectives of DSRIP planners, administrators, and providers, and why were they successful or challenging?

This Evaluation Plan, prepared as required by the Special Terms and Conditions (STC)¹ and subject to Center for Medicare and Medicaid Services (CMS) approval, describes the methods that will be used by the Independent Evaluator to assess the extent to which the New York DSRIP achieved the intended goals and objectives of the program.

I. DSRIP Background and Overview

Medicaid Redesign Team (MRT)

Prior to efforts to redesign New York's Medicaid program, the nation's largest, Medicaid expenditures reached nearly \$53 billion in 2011 to serve 5 million people, which was twice the national average when compared on a per recipient basis. At best, New York was in the middle of the pack when it comes to health care quality. Similar to the nation as a whole, New York taxpayers were not getting their money's worth when it came to its Medicaid program. In addition to a high spending "base", New York's Medicaid program had seen significant growth. Some of this growth had been driven by the recession; however, other cost driver splayed a key role in program-wide spending which rose from \$46 billion in April 2007 to \$53 billion in 2011.

In addition to a cost problem, New York was having some significant health care quality issues. While national rankings tended to show New York in the middle of the pack when it comes to overall health care quality, those overall statistics masked major problems in areas such as avoidable hospital use, where New York ranks 50th in the country. Major disparities existed in health status among racial, ethnic, and socioeconomic groups in New York. These quality issues were not limited to Medicaid, but reflected in the entirety of the health care system. To address these underlying health care cost and quality issues, in January 2011, Governor Andrew Cuomo invited key Medicaid stakeholders to the table in a spirit of collaboration to address these underlying health care cost and quality issues, and see what could be achieved collectively to change course and rein in Medicaid spending, while at the same time improving quality.

Governor Cuomo's vision for collaboration was effectuated through Executive Order #5 which created the New York Medicaid Redesign Team (MRT). The MRT, made up initially of 27 stakeholders representing virtually every sector of the health care delivery system, including patient advocates, worked for nearly two months and developed a series of recommendations that not only lowered immediate spending – state share savings of \$2.2 billion in SFY 11-12 – but also proposed important reforms that will lead to improved health outcomes, as well as further savings in years to come. The MRT continued its innovative work in a second phase, breaking into work groups to address more complex issues, as well as monitoring the implementation of key recommendations enacted from their initial work. Perhaps the most important element of the MRT's Phase 1 plan was to enact a global Medicaid spending cap. This cap, which applies to the state share of Medicaid spending and is under the control of the Commissioner of Health, has fundamentally changed how state officials and stakeholders view the program. Every policy change must now be viewed in terms of what, if any, impact it will have on the allocation of finite Medicaid resources. Expenditures are tracked monthly and the figures are posted to the Department of Health web site so the public can observe how the program is performing relative to the spending cap. If spending appears on path to exceed the cap, the Commissioner of Health now has the authority to change reimbursement rates and implement utilization controls to rein in spending.

Governor Cuomo's Medicaid Redesign Team accomplished its mission. It developed a historic multi-year action plan that now has New York's Medicaid program on a path toward achieving the Triple Aim: *better care, better health and lower costs*. At the heart of the plan lies the notion that you can achieve the Triple Aim by ensuring that all Medicaid members access the most appropriate care in the most appropriate setting. This in turn is achieved by effectively managing care with special emphasis on the populations that are poorest served by the current "siloed" health care delivery system. These are the individuals who tend to fall between system cracks, utilize services inefficiently or not at all, experience diminishing quality of life and drive overall Medicaid costs. MRT is about fundamentally changing, for the better, the health care experience for these individuals which in turn will make the program affordable for state and federal taxpayers.

The MRT understood there is no single "silver bullet" solution to achieving the Triple Aim in New York Medicaid. Rather the plan includes more than 200 different initiatives that, in aggregate represent the most sweeping overhaul of New York's Medicaid program in state history. Virtually no part of the program remains unaffected.

While the plan is broad and comprehensive, it does rely heavily on five core strategies. These strategies are:

- o **Care Management for All:** All Medicaid members will be enrolled into comprehensive, fully integrated managed care plans. Those plans will continue to be held accountable for providing high quality of care, as well as for fundamentally changing the incentives in health care delivery by using payment reform to reward value over volume.

- o **Global Spending Cap:** State share Medicaid spending is now capped and is allowed to rise annually at the rate of medical inflation. This innovation has fundamentally changed how the program is managed and has brought tremendous transparency to the nation's largest Medicaid program.

- o **Health Homes:** Traditional managed care is not enough for many high needs Medicaid members. Health Homes go beyond the federal requirements and in New York are sophisticated multi-disciplinary networks of providers tasked with managing the care of high need individuals. Health Homes will, over time, evolve beyond care management and navigation to become Accountable Care Organizations (ACOs) specially built for high needs Medicaid members.

- o **High Quality Primary Care for All:** The goal is that all Medicaid members will utilize high quality primary care. This is achieved by providing incentive payments to providers to become NCQA accredited, and eventually to go above and beyond those standards to address other issues, such as behavioral health integration through a more advanced primary care model.

- o **Address the Social Determinants of Health:** Many Medicaid members face life challenges that prevent them from managing their own health. Unless these challenges are addressed head-on improved health and lower costs will never be achieved. Under MRT, New York is a national leader in addressing social determinants of health such as the lack of affordable housing and health disparities through innovative solutions like the MRT Supportive Housing Program.

New York is now more than three years into MRT plan implementation, and for the first time in over a decade year-on-year Medicaid spending was reduced while maintaining eligibility rules despite growing numbers enrolling in the program during the recent economic downturn. During its first full year of

operation (CY2012), total spending was reduced by \$4.6 billion, which led to over \$2 billion in savings for federal taxpayers. During that time New York Medicaid added 217,000 members in CY 2012, a 4.35 percent increase in enrollment. Success in reducing Medicaid spending has continued, remaining below projections into 2015.

In addition to cost containment success, important programs targeting quality improvement were successfully launched. One million additional Medicaid members are now utilizing NCQA accredited primary care providers and Health Homes are now available in almost every county in the state and are already delivering results. Over 121,000 members are receiving health homes services. Data from early Health Home enrollees suggest that the program is driving down both inpatient utilization and ER use.

Delivery System Reform Incentive Payment Program (DSRIP)

In April 2014, New York finalized terms and conditions with the federal government for the MRT Waiver amendment that will allow the state to reinvest \$8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment will enable New York to fully implement the MRT action plan to permanently restructure the health care system. Of the \$8 billion to be reinvested under the waiver, \$6.42 billion will be allocated to DSRIP for planning grants, provider incentive payments, and administrative costs. Additionally, \$500 million will be allocated to the Interim Access Assurance Fund, which will provide temporary, time-limited funding to ensure that viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption, and \$1.08 billion will be allocated to other MRT activities, including the development of health homes, investments in the long term care workforce, and enhanced behavioral health services through managed care contract payments.

DSRIP is a six-year demonstration project, starting with Year 0, which is the pre-implementation period and includes activities such as distribution of project grants, procuring entities to assist in the implementation of DSRIP, and finalizing the DSRIP operational protocol. Demonstration years (DY) 1-5 are DSRIP's operational years.

As a condition of receiving DSRIP funding, New York must develop and execute payment arrangements and accountability mechanisms with its managed care contractors which will involve amending contract terms that reflect new provider capacities and efficiencies in managed care rate setting. This will ensure the long-term sustainability of payment reforms, strengthened provider networks, and improved care coordination that will result from DSRIP.

The major program goals of DSRIP are 1) safety net system transformation at both the system and state level; 2) accountability for reducing avoidable hospital use and improvements in other health and public health measures; and 3) ensure sustainability of delivery system transformation through leveraging managed care payment reform.

DSRIP will achieve these goals through provider incentive payments to reward PPS's participating in DSRIP for undertaking projects designed to transform the systems of care that support Medicaid beneficiaries and low income uninsured. DSRIP projects must be designed to meet and be responsive to community needs while ensuring that overall transformation objectives are met. As such, all projects undertaken must contain the following elements:

1. Appropriate infrastructure, which may include changes in the healthcare workforce, ensuring access to care (with emphasis on outpatient care), and expansion of care coordination services.
2. Integration across settings, which involves creating links between different care settings (e.g., between inpatient and outpatient care or between physical and behavioral health care), with the goal of coordinating and providing care for patients across the spectrum of settings to promote health and better outcomes while managing the total cost of care.
3. Assuming responsibility for the health care needs of a defined population through community needs assessment and responsiveness to public health needs.
4. Procedures to reduce avoidable hospital use through the alignment of outpatient and inpatient settings, systems that take responsibility for a population, and investments in key infrastructure.

DSRIP Objectives, Milestones, Domains, Strategies, Projects, and Metrics

Objectives

PPS's will design and implement projects that aim to achieve each of the following objectives or sub-parts of objectives. These are elaborated further in the DSRIP Strategies Menu and Metrics (Attachment J)². Each PPS is responsible for project activities that address the first two objectives, for a defined population as specified in the third objective.

- a. The creation of appropriate infrastructure and care processes based on community need, in order to promote efficiency of operations and support prevention and early intervention.
- b. The integration of settings through the cooperation of inpatient and outpatient, institutional and community based providers, in coordinating and providing care for patients across the spectrum of settings in order to promote health and better outcomes, particularly for populations at risk, while managing total cost of care.
- c. Population health management as described in the attribution section of the Program Funding and Mechanics Protocol.³

Project Milestones

Progress towards achieving the goals specified above will be assessed by specific milestones for each project, which are measured by particular metrics that are further defined in the DSRIP Strategies Menu and Metrics (Attachment J).² These milestones are organized into the following domains:

a. Project Progress Milestones (Domain 1). Investments in technology, tools, and human resources that will strengthen the ability of the PPS(s) to serve target populations and pursue DSRIP project goals. Performance in this domain is measured by a common set of project progress milestones, which will include milestones related to the monitoring of project spending and post-DSRIP sustainability. This includes at least semi-annual reports on project progress specific to the PPS's DSRIP project and its Medicaid and uninsured patient population.

b. System Transformation Milestones (Domain 2). This domain includes outcomes that reflect the four subparts of the goal on system transformation, including measures of inpatient/ outpatient balance, increased primary care/community-based services utilization, and rates of global capitation, partial capitation and bundled payment of providers by Medicaid managed care plans, and measures for patient engagement.

c. Clinical Improvement Milestones (Domain 3): This domain includes metrics that reflect improved quality of care for Medicaid beneficiaries; including the goal of reducing avoidable hospital use and improvements in other health and public health measures. Payment for performance on these outcome

milestones will be based on an objective demonstration of improvement over a baseline, using a valid, standardized method. Systems that are already high performers on these metrics, with the exception of avoidable hospitalization metrics, before initiation of projects, must either explore alternative projects or align with lower PPS(s) such that the system as a whole has adequate room for improvement (as defined in DSRIP Program Funding and Mechanics Protocol (Attachment I)).

d. Population-Wide Strategy Implementation Milestones (Domain 4). DSRIP PPS(s) will be responsible for reporting on progress on strategies they have chosen related to the Prevention Agenda as identified in DSRIP Strategies Menu and Metrics (Attachment J) for relevant populations as identified in DSRIP Program Funding and Mechanics Protocol (Attachment I) and as approved in their project plan.

Projects Menu

Each PPS will employ multiple projects both to transform health care delivery and to address the broad needs of the population that the PPS serves. These projects as described in Attachment J are grouped into a set of strategies within three domains: System Transformation Projects (Domain 2), Clinical Improvement Projects (Domain 3), and Population-wide Projects (Domain 4). PPS's will be responsible for achieving a defined set of metrics for the projects selected from the strategies within these three domains. Domain 1 includes overall progress metrics that apply to all projects regardless of the Domain (2, 3, or 4) from which they were selected.

Project selection will be driven by the mandatory community needs assessment, and the rationale and starting point for each project must be described in the DSRIP project plan, as described in Attachment I. DSRIP project plans must include a minimum of five projects (at least two system transformation projects, two clinical improvement projects, and one population-wide project). As described further in Attachment I, a maximum of 11 projects will be considered for project valuation scoring purposes. Additional projects can be included in the application, but they will not affect the project valuation. The projects under each domain are described below. Additional project description can be found in the *NY DSRIP Project Toolkit*.⁴

Domain 1 includes overall progress metrics that apply to all projects regardless of the Domain (2, 3, or 4) from which they were selected. Metrics include preparation of semi-annual reports (e.g., reports on project status and challenges, updates on project governance), workforce milestones (e.g., net change in number of new MD's hired), and system integration milestones (e.g., percent complete of preapproved system integration plan contained in the PPS project plan). Core Domain 1 metrics are listed below:

1. Semi-annual reports (Pay for Reporting), which will include:
 - a. Project narrative on status and challenges
 - b. Information on project spending/budget and any other financial information requested by the state, including financial sustainability of system and projects.
 - c. Documentation on the number of beneficiaries served through the projects
 - d. Update on project governance
 - e. Update on workforce strategy implementation
 - f. Percent of providers that are reporting relevant DSRIP project data
 - g. Description of steps taken by the system to prepare for non-FFS reimbursement systems (including an update on any on-going negotiations with Medicaid managed care plans)
 - h. Engagement in learning collaboratives

2. Approval of DSRIP Plan (DY 1 only)

3. Workforce milestones (Pay-for-Reporting/ Pay-for-Performance, as specified in the *DSRIP Measure Specification and Reporting Manual*⁵)

- Percent Complete of System’s preapproved Workforce Plan Number of health care workers retrained/redeployed vs. # eligible based on system service changes
- Net change in number of new MDs hired – PCP; specialty
- Net change in number of new mid-levels providers hired
- Net change in number of other mid-level providers hired

4. System Integration milestones (Pay-for-Reporting/ Pay-for-Performance, as specified in the *DSRIP Measure Specification and Reporting Manual*⁵)

- Percent complete of preapproved system integration plan in the PPS project plan
- For Health Home population, % in Observed/Expected; % in Active Care Management; % with Care Plan

5. Additional project-specific metrics, established by the state or CMS for a particular project, especially “at risk” projects. (Pay for performance, i.e. achievement of corrective action as specified by the state or CMS for “at risk” projects) The state’s Independent Assessor will develop a rubric for assessing semi-annual reports, workforce milestones, and system integration milestones to identify at risk projects.

Domain 2 – System Transformation Projects. All DSRIP plans must include at least two projects from this domain based on their community needs assessment. At least one of those projects must be from strategy sub-list A and one from either sub-list B or C. PPS’s can submit up to 4 projects from Domain 2 for valuation and scoring purposes unless the PPS is also qualified to add project 2.d.i, which would be the fifth project. It is the expectation that all primary care practices in the PPS will meet 2014 NCQA Level 3 standards by the end of DSRIP Year 3. The 2014 NCQA Level 3 standards are aligned with Stage 2 Meaningful Use (MU) standards which are included in the metrics for Domain 2. In some of the projects, PCMH status is specifically noted and, in some, the requirement to meet these standards must be met by DSRIP Year 2. It is important in the development of PPSs to ensure involvement of a wide variety of health care, behavioral health, long term care (community based and facility based) and community providers to ensure success in system transformation projects. Implementation of system transformation projects should be done with a fresh view of how these multiple providers can be connected and utilized for their expertise to meet the goals of Domain 2. Domain 2 projects are listed below:

A. Create Integrated Delivery Systems (required)

2.a.i Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

2.a.ii Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))

2.a.iii Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.

2.a.iv Create a medical village using existing hospital infrastructure

2.a.v Create a medical village/alternative housing using existing nursing home

B. Implementation of Care Coordination and Transitional Care Programs

- 2.b.i Ambulatory Intensive Care Units (ICUs)
- 2.b.ii Development of co-located of primary care services in the emergency department (ED)
- 2.b.iii ED care triage for at-risk populations
- 2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions
- 2.b.v Care transitions intervention for skilled nursing facility (SNF) residents
- 2.b.vi Transitional supportive housing services
- 2.b.vii Implementing the INTERACT project (inpatient transfer avoidance program for SNF)
- 2.b.viii Hospital-Home Care Collaboration Solutions
- 2.b.ix Implementation of observational programs in hospitals

C. Connecting Settings

- 2.c.i. Development of community-based health navigation services
- 2.c.ii Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services

D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations

- 2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

Domain 3 – Clinical Improvement Projects. All DSRIP plans must include at least two projects from this domain, based on their community needs assessment. At least one of those projects must be a behavioral health strategy from sub-list A. PPS's can submit up to 4 projects from Domain 3 for valuation and scoring purposes. Domain 3 projects are listed below:

A. Behavioral Health (required)

- 3.a.i Integration of primary care and behavioral health services
- 3.a.ii Behavioral health community crisis stabilization services
- 3.a.iii. Implementation of evidence-based medication adherence program (MAP) in community based sites for behavioral health medication compliance
- 3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
- 3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes

B. Cardiovascular Health

Note: PPS's selecting cardiovascular health projects will be expected to utilize strategies contained in the Million Hearts campaign as appropriate (<http://millionhearts.hhs.gov/index.html>).

- 3.b.i Evidence-based strategies for disease management in high risk/affected populations (adult only)
- 3.b.ii Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adult only)

C. Diabetes Care

3.c.i Evidence-based strategies for disease management in high risk/affected populations (adults only)

3.c.ii Implementation of evidence-based strategies in the community to address chronic disease – primary and secondary prevention projects (adults only)

D. Asthma

3.d.i Development of evidence-based medication adherence programs (MAP) in community settings –asthma medication

3.d.ii Expansion of asthma home-based self-management program

3d.iii Implementation of evidence-based medicine guidelines for asthma management

E. HIV/AIDS

3.e.i Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations – development of a Center of Excellence for management of HIV/AIDS

F. Perinatal Care

3.f.i Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

G. Palliative Care

3.g.i Integration of palliative care into the PCMH Model

3.g.ii Integration of palliative care into nursing homes

H. Renal Care

3.h.i Specialized Medical Home from Chronic Renal Failure

Domain 4 – Population-Wide Projects. All DSRIP plans must include at least one project from this domain, based on their community needs assessment and consistent with the Domain 3 projects included in their project plan. Consistent means that it will add a new facet, but not be a duplicate, to the Domain 3 projects and be applicable to the full service area population. PPS's can submit up to 2 projects from Domain 4 for valuation and scoring purposes. The Domain 4 projects are based upon the New York State Prevention Agenda. While details of the allowed projects are included in the DSRIP Project Toolkit,⁴ additional details and supporting resources will be available on the Prevention Agenda website. Domain 4 projects are listed below:

A. Promote Mental Health and Prevent Substance Abuse (MHSA)

4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities

4.a.ii. Prevent Substance Abuse and other Mental Emotional Behavioral Disorders

4.a.iii. Strengthen Mental Health and Substance Abuse Infrastructure across Systems

B. Prevent Chronic Diseases

4.b.i. Promote tobacco use cessation, especially among low SES populations and those with poor mental health

4.b.ii. Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in Domain 3., such as cancer)

C. Prevent HIV and STDs

- 4.c.i Decrease HIV morbidity
- 4.c.ii Increase early access to, and retention in, HIV care
- 4.c.iii Decrease STD morbidity
- 4.c.iv Decrease HIV and STD disparities

D. Promote Healthy Women, Infants and Children

- 4.d.i Reduce premature births

Metrics

In order to measure progress towards achieving each objective, each project must include metrics, described in the *DSRIP Measure Specification and Reporting Manual*,⁵ in all four of the following domains. PPS's will report on these metrics in their semi-annual reports and will receive DSRIP payment for achievement of these milestones.

- i. Overall project progress metrics (Domain 1)
- ii. System transformation metrics (Domain 2)
- iii. Clinical improvement metrics (Domain 3)
- iv. Population-wide metrics (Domain 4)

PPS's that exceed their metrics and achieve high performance by exceeding a preset higher benchmark for reducing avoidable hospitalizations or for meeting certain higher performance targets for their assigned behavioral health population will be eligible for additional DSRIP funds from the high performance fund.

The Strategies Menu and Metrics (Attachment J) describes the specific metrics that will be used to assess performance under each domain and specifies which metrics are pay-for-reporting and which are pay-for-performance. Additional measure specifications, including the process for addressing small number issues are described in the *DSRIP Measure Specification and Reporting Manual*.⁵ The state or CMS may add Domain 1 metrics to a project prospectively in order to address implementation concerns with at risk projects.

All PPS's must have a target for all pay-for-performance metrics, which will be used to determine whether or not the performance target for the metric was achieved. Performance targets should be based on the higher of top decile of performance for either state or national data, or an alternative method approved by CMS. NY DSRIP goals for metrics may be based on NYS Medicaid results (preferred source) or national data where possible and on DSRIP DY1 results for metrics where state or national data are unavailable. Annual improvement targets for PPS metrics will be established using the methodology of reducing the gap to the goal by 10%. The most current PPS result (baseline for DY1 and so on) will be used to determine the gap between the PPS result and the measure's goal, and then 10% of that gap is added to the most current PPS result to set the annual improvement target for the current DY. Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

Semi-annual Reporting on Project Achievement

Two times per year, PPS's seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by the milestones and metrics described in their approved DSRIP plan. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for

the progress achieved. The PPS shall have available for review by the state or CMS, upon request, all supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- Reporting period of January 1 through June 30: the reporting and request for payment is due July 31.
- Reporting period of June 30 through December 31: the reporting and request for payment is due January 31.

These reports will serve as the basis for authorizing incentive payments to PPS's for achievement of DSRIP milestones. The state shall have 30 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. If additional information is requested, the PPS shall respond to the request within 15 days and the state shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided. The state shall schedule the payment transaction for each PPS within 30 days following state approval of the Performing Provider System's semi-annual report.

As part of CMS's monitoring of DSRIP payments, CMS reserves the right to review a sample of the PPS Reports and withhold or defer FFP if DSRIP milestones have not been met.

Note: Because many Domain 2, 3, and 4 metrics are annual measures, these annual measures will only be available to be reported once a year for purposes of authorizing and determining incentive payments.

DSRIP Beneficiary Attribution

The goal of DSRIP is to have each PPS responsible for most or all Medicaid beneficiaries in the given geography or medical market area. It is expected that most of the Medicaid beneficiaries (including dually eligible members) in the state will be attributed to a PPS. The possible exceptions are beneficiaries that are primarily being served by providers not participating in any PPS in the region. However, given the comprehensive nature of DSRIP, it is expected that each approved PPS will include all of the major providers of Medicaid services in their region, greatly reducing the number of beneficiaries not attributed to any PPS. A beneficiary will only be attributed to one PPS, based on the methodology described below.

PPS's must include a proposed target population, including a specific geography for the overall PPS effort. Each PPS will be approved for a specific geography, consisting of one or more counties, based on their application and the state's review. This specific geography will be utilized to form a service area for the purpose of attribution. Utilizing the proposed geography, for each DSRIP Project Plan submitted by a given PPS, the Department of Health will identify the Medicaid and uninsured beneficiaries' population (if applicable) that will be attributed to that system prospectively at the start of each measurement year. This prospective attribution denominator for DY 1 will be used in valuation for payment purposes without any adjustments applied, except at the midpoint evaluation. The attributed members will be the collective focus for all projects.

Matching Goal - The aim of the attribution process is to help assign a DSRIP participants to the best PPS based on the recipient's current utilization patterns, including assigned care management and primary care provider as well as the geographical appropriateness of that system. This means beneficiaries will be assigned to PPS's, in their region, which include the providers most responsible for their care (as determined based on visits to primary service types -including PCP). The attribution logic will test for a

plurality of visits within the PPS. Plurality, for DSRIP purposes, means a greater proportion of services as measured in qualifying visits within the PPS than from services outside the PPS.

Two Forms of Attribution:

DSRIP Attribution will come in two forms. The first form of attribution will be to initially assign a given cohort of patients to each PPS. This will be a 1 to 1 match between a PPS and each attributable Medicaid and uninsured member (uninsured members will be attached at the aggregate county level based on census data). This first form of attribution will be called *Attribution for Initial Valuation*. The second form of attribution will be for performance measurement purposes and will be done at the conclusion of each measurement year to create an appropriate group of members for DSRIP performance measurement purposes – this form of Attribution will be called *Attribution for Performance Measurement*.

1) Attribution for Initial Valuation:

This initial attribution is done for two basic purposes. The first purpose is to create a number of Medicaid and uninsured lives for use in the calculation of potential performance awards as part of the DSRIP valuation process. The second purpose is to create an initial group of Medicaid members only for initial performance benchmark development. Attribution for Initial Valuation will follow a logic flow based first on 1) the type of PPS and then 2) the population subcategory the given Medicaid member falls into.

PPS Type and Attribution:

Three PPS Types will be recognized for the purpose of Attribution for Initial Valuation:

a) Single PPS in a Region - If a PPS is the only PPS approved by the state in a defined region then all the Medicaid members receiving services in that region will be attributed to that single PPS. As previously promised by the State, the single PPS in a region will also receive all the non-utilizing Medicaid members (i.e., members enrolled in Medicaid but not receiving any Medicaid paid services) residing in their approved region in their attribution. In addition, the single PPS will receive all the uninsured residing in their approved region if they agree to do the 11th DSRIP project targeted to the uninsured.

b) Multi PPS in Region - Public Hospital Led/Involved – If a PPS that includes a major public hospital in their network (as lead, co-lead, or network partner) is approved in a region where there is at least one other approved PPS, then the public led/involved PPS will receive all utilizing Medicaid members (with the exception of some low utilizing Medicaid members) that get most of their services from the PPS network through the loyalty assignment methodology. This public led/involved PPS will also be given the first opportunity to develop an 11th project specifically designed to serve the uninsured in its region. If this public led/involved PPS opts to do that 11th project, they will then also have all the uninsured members residing in their approved region attributed to their PPS for initial valuation. This public led/involved PPS will also receive (for attribution for payment purposes and again only if they do the 11th project) a cohort of non-utilizing and low use Medicaid members in the region. Low use members are those that meet a state definition of lower use designed to target members with use patterns that appear to not be coordinated by PCP or care manager during the attribution period (e.g., ED visits with no evidence of PCP access, Inpatient visits with no primary care etc.). All of these low use members may however be included in the attribution denominators for measurement purposes (and baseline data) based on their current access patterns. This cohort of non-utilizing and low utilizing members will be utilized in attribution and valuation for all Public hospital Led/Involved PPSs and any non-public PPSs approved to do the 11th project as discussed below. This non-utilizing and low utilizing cohort will be determined at the conclusion of the DSRIP application review.

c) Multi PPS – Non Public Involved – If the PPS is approved in a region that contains at least one other PPSs approved for all or part of their approved region (Multi PPS) and this region does not include a major public hospital as a major partner in their network, then this non-public involved PPS will receive attribution of utilizing Medicaid members that get most of their services from their PPS network in the loyalty assignment methodology described below. This non-public multi-PPS type is only eligible to receive uninsured and a cohort of low/non-utilizing Medicaid members under one of two scenarios – 1) there is no public PPS in the region or 2) there is a public PPS in the region but the public PPS has opted not to do the 11th project. If scenario 1 or 2 materializes, the non-public PPS(s) would then have the option to elect to pursue the 11th project. If the non-public PPS(s) decides to pursue the 11th project, they will then be eligible to receive uninsured and a cohort of low/non-utilizing Medicaid members in their attribution. If a public led PPS is approved in the region and that public PPS opts not to do the 11th project, then the non-public PPS(s) in the region will be offered an opportunity to do so. If the non-public PPS(s) selects the 11th project, then they will be assigned the uninsured members residing in their approved PPS region in the attribution for initial valuation based on the percentage of Medicaid members assigned to the PPSs in the region (for example, if a given non-public PPS has 60 percent of the region’s Medicaid population attributed then they will get 60 percent of the uninsured members). So, if no public led PPS exists in the region or the public declines to do the 11th project, the uninsured members will be divided between any Non-public PPS(s) (once the opt to do the 11th project) based on the percentage of Medicaid members assigned to the PPSs in the region. Also, the cohort of the low/non utilizing Medicaid population will be attributed to the any Non-public PPS(s) using the same method as the uninsured are distributed; again they will be assigned this population only if they opt to do the 11th project.

Attribution for Initial Valuation Logic – Loyalty Based Attribution for Regions with Multiple PPS

Utilizing Medicaid members will be attributed first based on what population subcategory they belong to and second based on the attribution loyalty logic that has been specifically designed for that given subpopulation by the state.

Four mutually exclusive population subcategory groupings have been set up for DSRIP purposes:

- Developmental Disabilities (OPWDD Service Eligible – Code 95)
- Long Term Care (Only NH residents)
- Behavioral Health (SMI/Serious SUD)
- All Other

Medicaid members will be placed into one of these population subcategories based on a mutually exclusive hierarchy in the order presented above. In other words, the logic will first look for evidence of Developmental Disabilities and if none exists then evidence of Long Term Care, and if none exists then Behavioral Health, and if none exists then the member will be assigned to All Other. So, for example, if the member meets criteria for Developmental Disabilities and Long Term Care they will be assigned to Development Disabilities as that is first in the hierarchy. Similarly, if a member does not meet criteria for Developmental Disabilities but does meet criteria for both Long Term care and Behavioral Health they will be assigned to Long Term Care. After a member is assigned to a population subcategory they will then been assigned to a PPS based on a loyalty algorithm that is specific to their population subcategory. For instance, if they have been assigned to the Behavioral Health subcategory the algorithm will check first for care management/health home connectivity and if none exists go on to look for residential connectivity and then ambulatory and so on in hierarchical order.

It should be noted that the majority of members will be attributed from within the “All other” category above. It is estimated that over 80 percent of Medicaid members will be attributed from within that category. Further, while some members in the All Other category with multiple chronic illness will be attributed based on their health home care management agency, clearly most of the All Other members are going to be attributed to a DSRIP network based on their health plan assigned PCP as most patients are in health plans and many of those members are utilizing their assigned PCP. If a non-health home member in the “All Other” is not utilizing the assigned PCP they will then be attributed based upon the primary care provider or clinic that they see most often for ambulatory care. If no ambulatory care exists they will then be attributed based upon emergency department and then inpatient use if necessary. *Irrespective of the final attribution, each PPS will be required to make ongoing efforts to work with health plans and providers to align care management, PCP and specialty services for all attributed members in such a way to fully leverage existing positive clinical relationships.*

The results of the preliminary attribution process above will be shared with the Medicaid Managed Care organizations for their enrolled members. The MCOs will review the state’s attribution logic/results and suggest any needed changes based on more current member utilization information including more recent PCP assignment or specialty service access. In advance of this attribution process the state will share the DSRIP PPS network with the plan to identify any network alignment gaps that may exist so that the DSRIP PPS and the MCOs can work together to align service delivery and plan contracted networks as appropriate.

PPS Networks and Attribution for Initial Valuation - Once the PPS network of service providers is finalized, each PPS service network will be loaded into the attribution system for recipient loyalty to be assigned based on visit counts to the overall PPS network in each of the above hierarchical population subcategories. Once the initial attribution is calculated for the purposes of setting DSRIP project values, the PPS network may only be changed with a DSRIP plan modification. For each of these population subcategories, the algorithm will check the services provided by each provider and accumulate these visits to the PPS the given provider is partnered with. If a recipient is currently outside the PPS geographic area, the visits are excluded (e.g. recipient traveling from upstate to NYC for special surgery). Each PPS associated with the matched provider accumulates the total number of visits for each service/provider combination. Adjustments to attribution based on known variables (e.g. recent changes to the recipient’s address) may be made by the state with MCO input if deemed necessary by data. After all visits against all providers are tallied up for a given service type, the methodology finds the PPS with the highest number of visits for the recipient in each service loyalty level as appropriate. If a single provider is in more than one PPS network (e.g., PCP) then the tie breaking method below may be employed for final matching purposes. This overall process will be designed to ensure that the PPS that is the best fit for the recipient is chosen.

Finalizing Match and Ties - If more than one PPS has the highest number of visits based on the highest priority service loyalty types noted, the methodology re-runs the above logic across all Medicaid service types. This process could break a tie if additional visits in other service types cause one PPS to accumulate more visits. So for instance, Nursing Home residents that are in nursing homes with connectivity to multiple PPSs may be placed based on their utilization of hospital or other services. If, however, this still results in a tie, the methodology will place the recipient in a separate bucket to be assigned at the end of the process. Recipients who have no predominant demonstrated provider utilization pattern will be assigned to a PPS based on a special logic. If the member is not matched from within the Developmental Disabilities, Long Term Care or Behavioral Health population subcategories the PPS in their geographic region will be chosen by first looking to see if the beneficiary has any primary

care provider (PCP) assigned by a Medicaid health plan; if the beneficiary has an assigned PCP the beneficiary will be matched to the PPS that has that PCP in their network (a method will be developed to address PCPs that are in more than one PPS). For all population subcategories, if the beneficiary cannot be matched by PCP, then the beneficiary will be assigned to the PPS with the most beneficiaries already assigned (by the visit attribution method) in their specific zip code or other relevant geographic area. Except for beneficiaries who are explicitly excluded because they receive the majority of their services (more than 50%) at providers that are not participating in DSRIP, all beneficiaries will be attributed.

2) Attribution for Performance Measurement Purposes

Although the patient populations targeted for PPS measurement will be determined as of January 1 (or other date specified) of the measurement year for valuation purposes, patient attribution for PPS quality measurement for Domain 2 and 3 metrics will be defined as of the measurement period. This is consistent with the CMS Medicare Shared Savings Program (MSSP), where there is an initial, prospective attribution at the start of the measurement year to determine the populations to be included and a final attribution at the end of the year for evaluation and measurement. Each patient will be assigned to only one PPS for measurement purposes. The patient population attributed for valuation will form the basis for quality measurement for all population-based measures (see *Measure Specification and Reporting Manual*⁵) with the appropriate criteria applied for each measure. For episodic-based measures, the initial population attributed to each PPS will be limited to only those members seen for that episode of care within the PPS network during the measurement period. Episode of care refers here to all care provided over a period of time (as defined in the measurement specifications) for a specific condition (e.g. Diabetes - all diabetes care received in a defined time period for those members; HIV- all HIV care received in a defined time period for those members). Since PPS networks are non-binding and members can choose to receive care outside of network, it is necessary to protect patient confidentiality for certain highly sensitive medical conditions, as well as, ensure medical records are available to the PPS network for all hybrid measures. For institutional-based measures the population for quality measurement will represent the population within that facility.

Valuation

Valuation for DSRIP Application

The maximum DSRIP project and application valuation will follow a five-step process.

1. The first step assigns each project in the Strategy Menu (Attachment J) a *project index score* which is a ratio out of a total of 60 possible points of each project ($X/60 = \text{project index score}$).
2. The second step creates a *project PMPM* by multiplying the project index score by the state's valuation benchmark. The valuation benchmark is pre-set by the state and varies based upon the number of projects proposed by an applicant.
3. The third step determines the *plan application score* for the Performing Provider System's application based on a total of 100 points possible for each application ($X/100 = \text{Application Score}$).
4. In the fourth step, the *maximum project value* is calculated by multiplying the project PMPM, the plan application score, the number of beneficiaries attributed to the project, and the duration of the DSRIP project.
5. Once the maximum project values have been determined, the *maximum application value* for a PPS is calculated by adding together each of the maximum project values for a given PPS's application.

The maximum application value represents the highest possible financial allocation a PPS can receive for their Project Plan over the duration of their participation in the DSRIP program. PPSs may receive less

than their maximum allocation if they do not meet metrics and/ or if DSRIP funding is reduced because of the statewide penalty.

Metric valuation

Once the overall project valuation is set, incentive payment values will be calculated for each metric/milestone domain in the DSRIP project plan by multiplying the total valuation of the project in a given year by the specified milestone percentages.

Within each metric/milestone domain and pay-for-performance/ pay-for-reporting grouping, the value for each metric/milestone will be equally divided between all metrics in a given grouping per the process that follows.

Providers will receive DSRIP payments based on achievement of reporting milestones (P4R) and/or performance targets for metrics (P4P) for a given project during a performance period. Within each project, the value for achieving each performance target/milestone is the same (evenly weighted) and will be calculated as “meeting” or “not meeting” the performance target/milestone. The points given for reaching a specified performance target/milestone will be called an Achievement Value (AV) and will be calculated as a 0 or 1 value. If a performance target or reporting milestone is met, the PPS will receive an AV of 1 for that performance target/milestone in that reporting period. If the PPS does not meet its milestone or performance target, the PPS will receive an AV of 0 for that reporting period. This will be done across every project in every domain.

PPS improvement targets will be established annually using the baseline data for DY 1 and then annually thereafter for DY2-5. High level performance targets will be provided by the State using results from managed care reporting data in DY1 and using results from DSRIP projects in DY2-DY5. The Achievement Value for P4P metrics will be established by comparing the PPS result for the reporting period with the improvement target for the PPS. If the PPS meets the improvement target for the metric, the PPS will receive an AV of 1. If the PPS result also meets a high performance threshold, there may be additional payment through High Performance fund, which is not included in this part of the payment calculation.

AVs will then be grouped into either a pay-for-reporting (P4R) or a pay-for-performance (P4P) bucket for each domain. The P4P and P4R AVs in each domain will be summed to determine the Total Achievement Value (TAV) for the domain. A Percentage Achievement Value (PAV) will then be calculated by dividing the TAV by the maximum AV (the total number of metrics) for P4P and P4R in each domain. The PAV will demonstrate the percentage of achieved metrics within the P4R and P4P metrics for each domain for that reporting period.

Payment Based on Milestone Achievement for DY 1 – DY 5

Incentive payments are calculated separately for each project. The amount of the incentive funding paid to a provider will be based on the amount of progress made within specific milestones and the valuation of those milestones.

Half of the incentive funding for Domain 1 in DY 1 will be awarded for approval of the DSRIP plan.

Fifteen percent will be paid upon the delivery of an acceptable first semiannual report. Fifteen percent will be paid upon the delivery of an acceptable second semiannual report.

For each metric, the provider will include in the required DSRIP provider report the progress made in completing each metric along with sufficient supporting documentation. Progress for a given metric will be categorized as fully achieved or not achieved. If a provider has previously reported progress in a

domain and received partial funding after the first semi-annual reporting period, only the additional amount is eligible for funding in the second semi-annual reporting period.

Payments from the High Performance Fund

PPS's who have achieved performance improvement beyond the stated target improvement value in their approved DSRIP project plan will be eligible for additional payment from the DSRIP high performance fund, not to exceed 30 percent of their DSRIP project value.

A half of the high performance fund will be available for tier 1 payments, and half will be available for tier 2 payments which will be distributed as follows:

- Higher performing participating providers whose performance closes the gap between their current performance and the high performance level by 20 percent shall receive Tier 1 level reward payments.
- Higher performing participating providers whose performance meets or exceeds the high performance level (90th percentile of statewide performance) shall receive Tier 2 level reward payments.

High performance fund payments shall be adjusted based on Medicaid and indigent population size served by the project being implemented by the provider. The percentages above may be adjusted up or down by the State for each metric as appropriate to account for volume of demand on the high performance fund.

The state, working with the quality committee, will set a high performance threshold for the measures described in attachment J specifically avoidable hospitalizations for the entire attributed population and separate high performance targets (physical and behavioral metrics) for the behavioral health population subset. High Performance payments will be based on attaining 20 percent gap to goal or the 90th percentile of statewide performance on the high performance metrics.

Program Monitoring

With the assistance of the Independent Assessor, New York will be actively involved in the ongoing monitoring of DSRIP projects, including but not limited to the following activities:

1. *Review of milestone achievement.* At least two times per year, PPS's seeking payment under the DSRIP program shall submit reports to the state demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The PPS shall have available for review by New York or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to PPS's for achievement of DSRIP milestones.
2. *Quarterly DSRIP Operational Protocol Report.* The state shall provide quarterly updates to CMS and the public on the operation of the DSRIP program. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration. The reports will document key operational and other challenges, to what they attribute the challenges and how the challenges

are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

3. *Learning collaboratives.* With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be a required activity for all PPS's, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects. Learning collaboratives are forums for PPS's to share best practices and get assistance with implementing their DSRIP projects.
4. *Rapid cycle evaluation.* In addition to the comprehensive, statewide evaluation of DSRIP, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.
5. *Additional progress milestones for at risk projects.* Based on the information contained in the Performing Provider System's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period. Projects that remain "at risk" are likely to be discontinued at the midpoint assessment.
6. *Annual discussion and site visits.* In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned. The state, the independent assessor, and CMS will conduct annual site visits of a subset of PPS's to ensure continued compliance with DSRIP requirements.
7. *Application, review, oversight, and monitoring database.* The state will ensure that there is a well maintained and structured database, containing as data elements all parts and aspects of Performing Provider Systems' DSRIP project plans; independent assessor, state, and CMS review comments and scores; project planning, process, improvement, outcome, and population health milestones, with indicators of their required timing, incentive payment valuation, and whether or not they were achieved; and any other data elements required for the oversight of DSRIP.

II. Research Design

In addition to the ongoing program monitoring activities described above, New York will conduct a multi-method, robust statewide evaluation to document the impact of DSRIP on health care service delivery, health improvements, and cost to the Medicaid program, as well as to determine program components that posed particular successes or challenges for implementation and outcomes. The broad goals of the New York DSRIP evaluation are to 1) assess program effectiveness on a statewide level with respect to the MRT Triple Aim of improved care, better health, and reduced cost, 2) conduct PPS-level comparisons to obtain information on the effectiveness of specific projects and strategies selected and the factors associated with program success, and 3) obtain feedback from stakeholders including DSRIP planners, administrators, providers and patients, regarding the planning and

implementation of the DSRIP program and, and on the health care service experience under DSRIP reforms. Toward these goals, the following questions will be addressed:

1. To what extent did PPS's achieve health care system transformation?
2. Did health care quality improve as a result of clinical improvements in the treatment of selected diseases and conditions?
3. Did population health improve as a result of implementation of the DSRIP initiative?
4. Did utilization of behavioral health care services increase as a result of DSRIP?
5. Was avoidable hospital use reduced as a result of DSRIP?
6. Did DSRIP reduce health care costs?
7. What were the successes and challenges with respect to PPS planning, implementation, operation, and plans for program sustainability from the perspectives of DSRIP planners, administrators, and providers, and why were they successful or challenging?

Method

Approach

Figure 1 shows a logic model depicting the New York DSRIP program, identifying the expected short-term, intermediate, and long-term program outcomes, providing a guiding framework the evaluation. The evaluation will use quantitative methods to assess program outcomes on both the statewide and PPS levels using existing data sources. Qualitative data will be used to provide context for the quantitative findings, as well as to obtain insights on program functioning and effectiveness on the PPS level from administrative, provider, and patient perspectives. Quantitative and qualitative comparisons will be made on the PPS level in an effort to assess strategy and project effectiveness, and to obtain information on factors associated with successes or challenges in project implementation and in achieving intended outcomes.

Quantitative Analysis

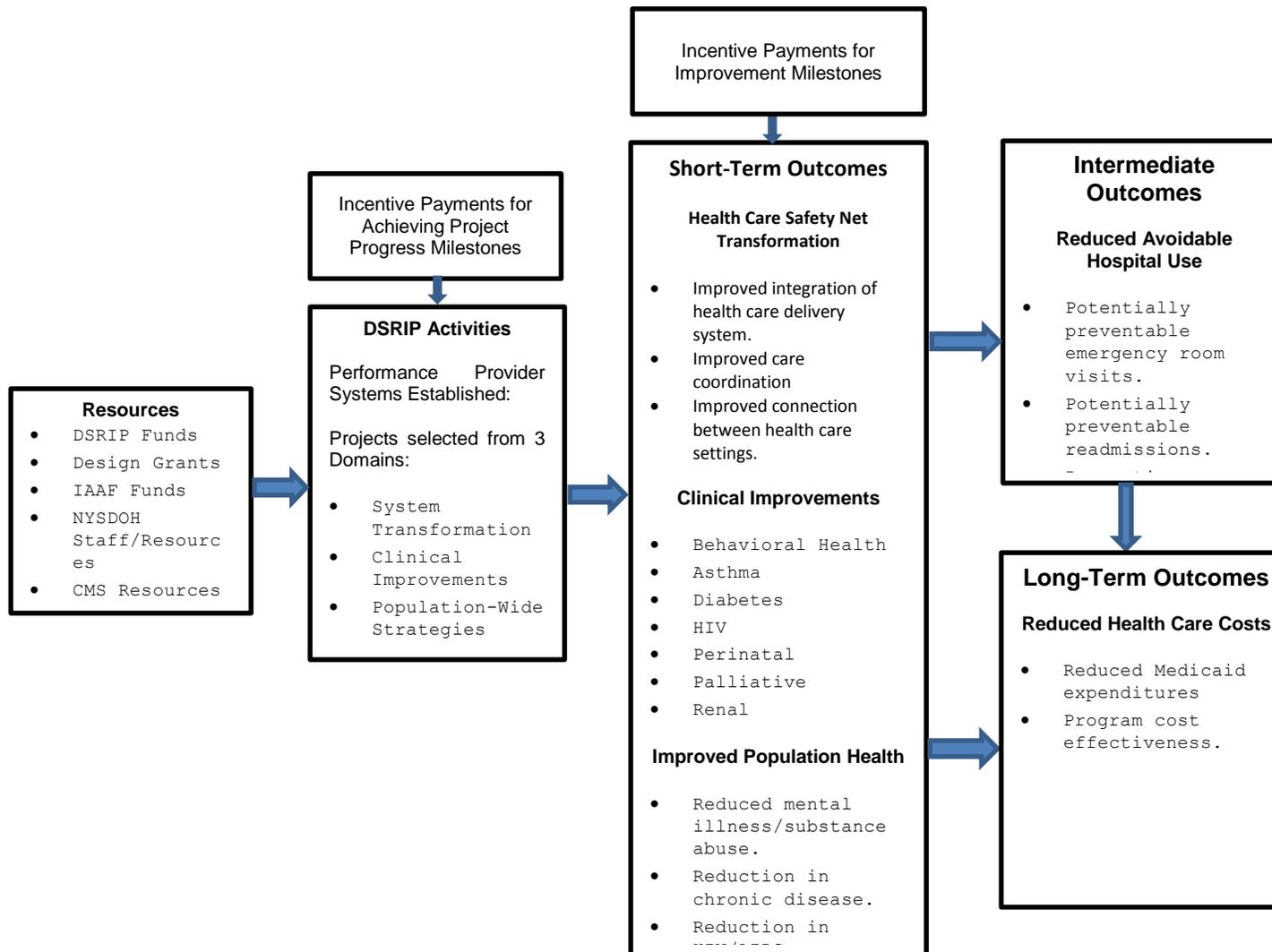
Quantitative analysis to assess the effect of DSRIP on a statewide level will emphasize comparison of health outcomes over the study period following the implementation of DSRIP to the study period prior to DSRIP's implementation. Specifically, it is hypothesized that the following changes will occur under New York's Medicaid program as a result of the DSRIP initiative:

13. Health care service delivery will show greater integration.
14. Health care coordination will improve.
15. Primary care utilization will show a greater upward trend.
16. Expenditures for primary care services will increase.
17. Utilization of, and expenditures for, behavioral health care service will increase.
18. Expenditures for emergency department and inpatient services will decrease.
19. Primary care, behavioral health, and dental service utilization will increase among the uninsured, non-utilizing, and low-utilizing populations, while emergency department use will decrease.
20. Through clinical improvements implemented under DSRIP, health care quality in each of the following areas will increase:
 - i. Behavioral health

- j. Cardiovascular health
 - k. Diabetes care
 - l. Asthma
 - m. HIV/AIDS
 - n. Perinatal care
 - o. Palliative care
 - p. Renal care
21. Population health measures will show improvements in the following 4 areas:
 - e. Mental health and substance abuse
 - f. Prevention of chronic diseases
 - g. Prevention of HIV and STD's
 - h. Health of women, infants, and children
 22. Avoidable hospital use will be reduced.
 23. Costs associated with hospital inpatient and ED services will show reductions or slowed growth
 24. Total cost of care will show reductions or slowed growth

For consistency in the use of metrics, as well as for their appropriateness for use in assessing the statewide impact of DSRIP, the evaluation will primarily employ the measures described in the DSRIP Strategies Menu and Metrics, Attachment J², in testing these hypotheses.

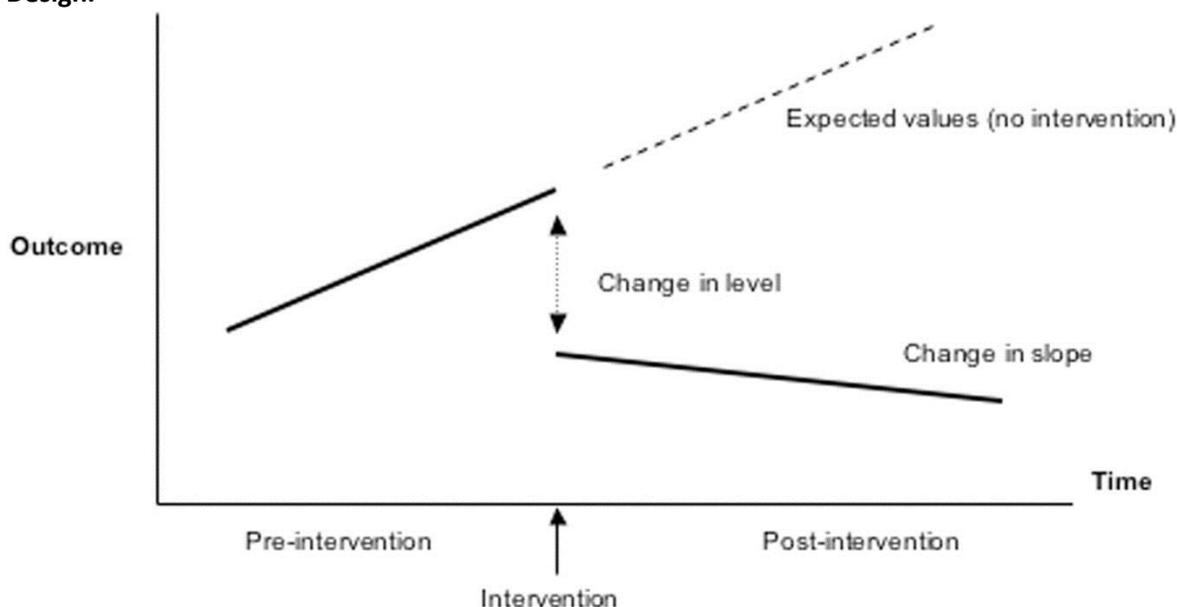
Figure 1. Delivery System Reform Incentive Payment Program (DSRIP) Logic Model



Existing data available within the New York Department of Health, described in a section to follow, will be used to calculate the measures.

An interrupted time series design⁶ is proposed to test these hypotheses in assessing DSRIP’s statewide impact. This is a quasi-experimental design in which summary measures of the outcome variable are taken at equal time intervals over a period prior to program implementation (independent variable), followed by a series of measurements at the same intervals over a period following program implementation, as shown in the idealized illustration in Figure 2. This design was chosen in consideration of the fact that a non-DSRIP control group is unlikely to be available, limiting the ability to separate the effects of DSRIP from other statewide health care reform initiatives that are ongoing such as the New York Prevention Agenda, the State Health Innovation Plan (SHIP) with the support of the State Innovation Models (SIM) grant, the Affordable Care Act, and other concurrent market forces. Given the limitation resulting from the likely absence of a comparison group, this design is advantageous in that potential confounders (i.e., other health care reform initiatives) are minimized in that they would have to occur contemporaneously with the introduction of DSRIP in order to exert a confounding effect, which is unlikely, but is recognized as possible nonetheless. This design also has the advantage of accounting for secular trends in the outcome variables, to which other non-DSRIP health reform initiatives would be expected to contribute. Given the potential to strengthen the design with respect to causal inference, augmentation of the statewide interrupted time series design by the use of a non-DSRIP control group may be proposed by Independent Evaluator applicants, however, there are several issues to consider. First, since the intent of DSRIP is to cover all Medicaid recipients and the low-income uninsured, a comparable non-DSRIP control group within this population may be difficult to identify. Second, it is expected that DSRIP effects will carry over to non-DSRIP populations since (1) it will not be known at the point of care if someone is covered under DSRIP, and PPS providers cannot restrict care to only those covered under DSRIP, and (2) changes in provider practices to improve the delivery of care will likely be experienced by non-DSRIP populations being served by the same providers. Finally, a non-Medicaid population that could potentially be used as a control group would likely differ in many respects, including demographically, socioeconomically, and by health status.

Figure 2. Pre- and Post-Intervention Comparison of Outcome Variable using Interrupted Time Series Design.



Segmented regression⁷ will be used as the primary analytic strategy in the analysis of data under the interrupted time series design. This analysis enables the evaluation of changes in the level and trend in the outcome variable, while controlling, as necessary, for such biases as secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. A potential issue to address over DSRIP's five-year demonstration period is change in characteristics of the Medicaid population over that time. This could occur through increased enrollment of younger and healthier people into Medicaid, and/or increased movement of older and sicker people from Medicaid fee-for-service to managed care, either of which could confound the effects of DSRIP's implementation on the outcomes. This will be addressed through adjustment of the outcome variables by standardizing on factors such as age, sex, and health status (e.g., Clinical Risk Grouping⁸, Charlson Comorbidity Index⁹), or inclusion of population-level measures of these variables as covariates in the model. Stratification will be used to assess differential program outcomes by recipient subgroups (e.g., sex, race, age, mental health status).

For segmented regression analysis, it has been recommended that there be a minimum of 8 observation points both pre- and post-intervention for sufficient power to detect changes in level and trend.¹⁰ The majority of outcome measures will be calculated in three month intervals over five years prior to the implementation of DSRIP, with April 2010 as the baseline year, and again in the same manner following the implementation of DSRIP ending in April 2019, for a total of 20 observation points both pre-and post-intervention, exceeding this 8 observation criterion. Some of the data sources to be used, however, will not be collected with sufficient frequency to allow quarterly measurement of the outcome variables derived from those sources. In such cases where the number of time points may be not be optimal, two approaches to address this issue will be employed, as appropriate. First, the use of alternative data sources containing the necessary information will be considered. For example, data on flu shots received by adults age 50-64 would be documented with greater frequency in Medicaid claims data, and thus allowing measurement at a greater number of time points, as opposed to obtaining the information from BRFSS survey data, which are gathered only once per year. A second approach to be considered in the absence of sufficient data points will be the inclusion of additional pre-intervention data points, increasing the power to detect secular trends.

A set of measures described in the DSRIP Strategies Menu and Metrics² will be used to quantify facets of system transformation (Domain 2), quality of care through clinical improvements (Domain 3), and population health (Domain 4). Using existing data sources, these measures will be used for purposes of the DSRIP evaluation in assessing statewide outcomes, in addition to the program monitoring activity of determining incentive payments. The majority of these measures are well established with known measurement stewards (e.g., 3M, AHRQ), and are commonly used in health care quality improvement activities.

That the evaluation of the NYS DSRIP evaluation will involve the testing of a large number of hypotheses poses the problem of inflated type I error rate. The method to be adopted to address this issue will be the control of the false discovery rate (FDR),¹¹ defined as the expected proportion of errors (i.e., null hypotheses that are actually true) among a set of null hypotheses that have been rejected. In contrast to traditional Bonferroni methods, which adjust significance levels based on the number of tests, control of FDR makes adjustments in significance levels based on the number of null hypotheses expected to be true among a set of tests. Control of the FDR has been demonstrated to preserve more power to detect real effects than do traditional Bonferroni-type adjustments, as well as overcoming other interpretational problems associated with Bonferroni procedures.¹²

Qualitative Analysis

While existing data sources such as Medicaid Claims, Statewide Planning and Research Cooperative System (SPARCS), and Vital Statistics will be used to assess program impact in the quantitative component of the evaluation, qualitative information obtained from DSRIP planners, administrators, providers, and beneficiaries will also play a vital role in the DSRIP evaluation. Qualitative methods will be used for two broad purposes:

3. To identify facilitators and barriers to PPS's achieving progress on pay-for-reporting/pay-for-performance metrics using feedback from PPS administrators, providers, and patients, as well as to identify these issues that are characteristic of particular strategies or projects.
4. To conduct PPS case study evaluation by obtaining information from DSRIP stakeholders on an ongoing basis on program planning, implementation, operation, and effectiveness to guide quality improvement through project refinements and enhancements.

The major qualitative methods to be used will be key informant interviews, focus groups, and surveys, with issues to be investigated qualitatively to include notable program outcomes and challenges, effectiveness of governance structure and provider linkages, contractual and financial arrangements, changes in the delivery of patient care, the effect of other ongoing health care initiatives (e.g., New York Prevention Agenda, Affordable Care Act) on DSRIP implementation and operation, and patient experience and satisfaction with services. The Independent Evaluator will develop key informant and focus group interviews to address the questions under each objective. Development will include the determination of interview questions with appropriate review and pre-testing to ensure that questions are comprehensive, understandable, and reliable.

Interviews and focus groups will be semi-structured such that questions to be asked will be uniform across participants, while at the same time allowing for follow-up questions to probe for more in-depth responses. Modifications in the interview questions will be made as necessary based on responses obtained on early interviews. Analysis will follow a framework described by Bradley, Curry, & Devers.¹³ A coding structure will be established through a review of the data to identify concepts, relationships between concepts, and evaluative participant perspectives (i.e., statements that are positive, negative, or indifferent to their experiences or observations). The coding structure will also capture respondent characteristics (e.g., age, sex, position or role in organization) and setting (e.g., PPS affiliation, type of PPS project, PPS region, or project strategy employed). Responses will then be re-reviewed independently by at least two evaluation staff members, applying the finalized coding structure. Coding discrepancies between reviewers will be resolved through discussion to achieve consensus for the final coding of the data. Coded data will be analyzed and interpreted to identify major concept domains and themes.

For selected evaluation questions, patient surveys will be developed. Surveys may be Web-based, administered in the form of in-person or phone interviews, or a mix of these methods. Data will be analyzed using statistical software in the case of closed-ended questions, or for open-ended questions that can be coded into categories. Open-ended questions that may elicit more complex responses will be analyzed in the same manner as the key informant and focus group data.

Interview and survey data will be developed and gathered on an annual basis from appropriate staff and beneficiaries from all PPS's. All interviews and surveys will be administered once during a demonstration year, and will contain questions/items pertinent to each research question, as described

in narrative to follow. Though key informant and focus group interviews will contain a common core of information, questions will be tailored to reflect the variation between PPS's with respect to strategies and projects implemented. All survey and interview protocols will be approved by the New York Department of Health Institutional Review Board, or other IRB, for human subjects research, and all evaluation staff involved in data collection will receive training on the handling and storage of confidential information.

Comparative Analysis

To address questions pertaining to the effects of type of projects adopted by PPS's, the relative effectiveness of specific strategies employed within project types, and the contextual factors associated with PPS success or failure to demonstrate improvement in the metrics associated with each domain, quantitative and qualitative comparative analyses will be conducted.

Quantitative comparisons on the PPS level will primarily employ difference-in-differences analysis, which allows the comparison of change between two time points on a specified outcome variable as a function of belonging to an intervention or control group while controlling for potential confounders.^{14,15} An assumption of difference-in-differences analysis is that the change in the outcome would have followed a parallel path for the two groups in the absence of the intervention, allowing any difference in the degree of change between groups to be attributable to the intervention. Using this approach, the majority of comparisons to be made will be of two broad types:

1. Where there is variation in the strategies selected per the PPS project requirements described in the STC documents,^{1,2} assess the effect on the pertinent outcome of PPS's having selected a strategy addressing a particular issue. For example, a comparison would be made in the improvement in diabetes care (Domain 2) between PPS's that implement a project focusing on diabetes care (i.e., a treatment group) and PPS's that do not (a control group), with the expectation that the magnitude of improvement would be greater for those PPS's in the treatment group.
2. Assessment of the relative effectiveness of particular projects intended to produce the same outcome. For example, among PPS's that opt for a strategy to improve asthma care, compare such improvement between those PPS's that chose to implement a project to expand asthma home-based self-management programs to those PPS's that chose projects to improve asthma care.

Qualitative comparisons using coded data obtained from key informant and focus group interviews with PPS staff and providers, along with patient survey data on service experience and satisfaction, will be analyzed and interpreted to identify differences in major concept domains and themes between PPS's in an effort to identify areas of success, along with providing feedback about those areas in need of improvement with respect to the planning, implementation, and operation to enable modifications and refinements of DSRIP projects. Between-PPS comparisons will be specific to each evaluation question, but will include:

1. Comparisons based on the degree to which maximum payment was received based on project valuation to identify factors common to those PPS's receiving or not receiving maximum payment.
2. Comparisons between PPS's based on the degree to which improvement was demonstrated on specific quantitative outcomes, e.g., achievement of performance targets on pay-for-performance metrics or improvement on pay-for-reporting metrics.
3. PPS comparisons by strategy or project selected to obtain insights on their effectiveness.
4. Comparisons between PPS's operating in different regions of New York to identify successes and challenges associated with local resources or procedures.

5. Patient-level comparisons by factors such as age, sex, race, presence of selected chronic conditions, and mental health/substance abuse status to obtain information on variations in service experience and satisfaction under DSRIP by patient characteristics.

Reporting

In accordance with the STC¹, an Interim Evaluation Report will be submitted to CMS by March 30, 2019, containing results from data available for reporting by that date, followed by a Summative Evaluation Report due to CMS by December 28, 2020, to include results through the entire 5-year demonstration. The latter will contain the major results and conclusions with respect to DSRIP's operation and effectiveness over all five years of the demonstration. In addition to these two primary evaluation products, DSRIP evaluation results will be shared, via an annual report, with state policymakers, as well as PPS planners, administrators, and providers in order to highlight areas of success, as well as those in need of improvement, in order to guide any needed program modifications and enhancements. Results from interviews and surveys administered on the PPS level will be reported back to those PPS's on an annual basis, with the expectation that receipt of information that is specific to their own projects will assist their ongoing quality improvement efforts.

Methods for Addressing Evaluation Questions

Question 1: To what extent did Performing Provider Systems achieve health care system transformation, including increasing the availability of behavioral health care?

All PPS's will be required to select two projects under Domain 2, which contains a menu of projects addressing health care system transformation. STC Attachment J describes three categories of potential projects under this domain as follows:

A. Create Integrated Delivery Systems (required)

- *Create Integrated Delivery Systems that are focused on Evidence Based Medicine / Population Health Management*
- *Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the New York Health Innovation Plan (SHIP))*
- *Health Home At-Risk Intervention Program –Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services. 2.a.iv Create a medical village using existing hospital infrastructure*
- *Create a medical village/ alternative housing using existing nursing home*

B. Implementation of care coordination and transitional care programs

- *Ambulatory ICUs*
- *Development of co-located of primary care services in the emergency department (ED)*
- *ED care triage for at-risk populations*
- *Care transitions intervention model to reduce 30 day readmissions for chronic health conditions*
- *Care transitions intervention for skilled nursing facility residents*
- *Transitional supportive housing services*
- *Implementing the INTERACT project (inpatient transfer avoidance program for SNF)*
- *Hospital-Home Care Collaboration Solutions*
- *Implementation of observational programs in hospitals*

C. Connecting settings

- *Development of community-based health navigation services*
- *Expand usage of telemedicine in underserved areas to provide access to otherwise scarce services*

D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations

- Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care.

One of the two projects must fall under category A, with the other must be selected from either category B or C. Eligible PPS's may select the project under category D as an additional project. Given the efforts under DSRIP to improve health care structure and delivery, changes in the following areas are expected:

1. Integration of service delivery.
2. Care coordination and connecting settings.
3. Availability and Use of Primary Care and Medicaid Primary Care Spending.
4. Availability and use of behavioral health services, and behavioral health care spending.
5. Medicaid spending on emergency department and inpatient services.
6. Access to and utilization of primary and preventative services by uninsured, non-utilizing, and low-utilizing populations.

Quantitative and qualitative methods to be used to investigate each of these 6 areas are discussed below. The outcomes, measures, and data sources used in these analyses are shown in Table 1, which appears later in this document.

1. Integration of service delivery.

The statewide impact of DSRIP on integration of service delivery as a key DSRIP outcome will be assessed using the interrupted time series design with segmented regression, as previously discussed. The hypothesis to be tested is that integration of service delivery will show an increase following the introduction of DSRIP. As shown in Table 1, two measures of service delivery integration, derived from the performance metrics, will be used as dependent variables in the analyses: Percent of eligible providers with participating agreements with Regional Health Information Organizations (RHIO's), and the percent of providers meeting Meaningful Use (MU) criteria and able to participate in bidirectional exchange.

Change in service delivery integration, a project for which is required of all PPS's, will also be investigated using qualitative data at the PPS level. This information will be used to address questions that cannot be addressed in the quantitative analysis, as well as provide context for PPS-level quantitative results. Questions pertaining to integration of service delivery are as follows:

1. What steps were taken within PPS project to achieve project goals?
2. What were some notable successes in implementing the service delivery integration project?
3. What challenges or barriers were encountered in implementing this project?
4. What organizational and contractual arrangements were made to implement this project?
5. What changes were made as a result of this project regarding the use of electronic health information?

6. What steps were taken as part of the projects to increase the availability and utilization of behavioral health services?
7. What other initiatives outside of DSRIP affect efforts to integrate service delivery, and how were those efforts affected?
8. What is the effect of attempting to increase service delivery integration on patient health care service experience in terms of access to primary care and specialty care, including behavioral health, and different providers' understanding of a patient's health history and status?

Focus group interviews with administrators and providers from each PPS will be developed to address questions 1-7. For question 8, a patient-level survey items will be developed and administered to Medicaid recipients receiving services under each PPS. Qualitative data will be collected annually to enable ongoing feedback to PPS administrators and providers to enable program modifications and refinements.

Comparison Analysis

Assessing the relative effectiveness of service delivery integration projects will be conducted by comparing PPS's implementing a given project (intervention group) to those that do not employ that project (control group). For inclusion in the Interim Evaluation Report, difference-in-differences estimation will be used to compare change in the two outcome variables from the start of Year 1 of the demonstration through the end of DY 3, controlling for PPS characteristics such as region, size (e.g., number of participating providers and Medicaid beneficiaries served), population demographics and health status, and, where possible, any other health care improvement initiatives outside of DSRIP that may be ongoing. For inclusion in the Summative Evaluation Report, overall change in outcome variables will be made between the intervention and control groups between Years 1 and 5, as well as between years 3 and 5.

PPS's that were, and were not, able to show improvement in service delivery integration on the basis of the pay for reporting metrics as determined by the Independent Assessor, will be compared on an annual basis, and this information will be used to inform the qualitative comparison of service delivery integration, with results between PPS's that demonstrated success in service delivery integration and those that did not to be qualitatively compared to identify differentiating factors. PPS's showing improvement in the integration of service delivery and those that do not will be compared in terms of:

- Steps taken to achieve project goals.
- Barriers encountered in implementing health care system transformation projects that focus on system integration.
- Organizational and contractual arrangements made to implement project.
- Other health reform initiatives outside of DSRIP that had an influence on efforts toward service delivery integration, and how such influence was exerted.
- Patient experience as a function of success or failure to improve service delivery integration with respect to access to primary care and specialty care, and provider understanding of patient health history and status, from the patient's perspective.

2. Care Coordination and Connecting Settings

The statewide impact of DSRIP on care coordination as an outcome variable will be assessed using the interrupted time series design with segmented regression. The hypothesis to be tested is that care

coordination will show improvement on a statewide basis following the introduction of DSRIP. As shown in Table 1, two measures of care coordination will be used as outcome variables in this analysis: A CAHPS measure of providers being up-to-date with respect to care being received from other providers, and an H-CAHPS measure of hospital care transition.

Qualitative data will be gathered at the PPS level regarding the implementation of a care coordination/connecting settings project. Key informant and focus group interviews will be conducted on an annual basis, and tailored to particular projects selected by the PPS, for participation by PPS administrators and providers. Questions will be tailored to individual PPS's based on the projects they initiated under the care coordination and connecting settings strategies, with the following broad questions to be addressed:

1. What were notable successes and challenges in implementing a care coordination or connecting settings project?
2. What were some of the barriers to information-sharing between providers?
3. What other health care reform initiatives outside of DSRIP influenced PPS efforts to improve care coordination and connecting of settings, and how?

Comparison Analysis

To assess the differential effectiveness of projects to improve care coordination/connecting settings, difference-in-differences analysis be used to compare, on the outcome variables, PPS's that undertook a particular project in this area to those implementing alternative projects. Examples of such comparisons to be made include PPS's that developed co-located of primary care services in the emergency department (ED) vs. those that implemented alternative care coordination projects, or comparing improvement in care coordination among PPS's implementing transitional supportive housing services vs. those implementing alternative projects. Comparisons to be made will be determined once PPS's have been selected and the distribution of projects is finalized. Analysis will assess differential change from DY 1 to DY 3, and from DY 3 to DY 5, and from DY 1 to DY 5 for the Summative Evaluation Report.

Qualitative comparisons of major themes will be made between PPS's that demonstrate quantitative success in care coordination vs. those that did not based on achievement of project milestones associated with these metrics, as determined by the Independent Assessor. Comparisons will also be made between PPS's adopting the same projects to identify commonalities in successes and areas that posed notable challenges that are specific to each project. These comparisons will be made with respect to:

- Specific successes and challenges associated with implementing a care coordination project.
- Barriers to coordinating care, with focus on information-sharing between providers.
- The positive and/or negative influences of other non-DSRIP initiatives on efforts to improve care coordination under DSRIP.

3. Availability and Use of Primary Care and Medicaid Primary Care Spending

The statewide impact of DSRIP on the use of primary care employing the interrupted time series/segmented regression approach will use the same measures as those used for pay for reporting/performance metrics: percent of primary care providers meeting patient centered medical home (PCMH)/advanced Primary Care criteria, and CAHPS survey questions about the usual source of

patient care loyalty, and Medicaid expenditures for primary care, as shown in Table 1. Though not used for the performance metrics, Medicaid claims data will also be used to assess pre/post change in primary care utilization (e.g., number of claims per member per month) with the introduction of DSRIP. It is hypothesized that primary care utilization by all three measures will show a greater upward trend following the introduction of DSRIP. It is also hypothesized that Medicaid overall and per member per month expenditures for primary care, as documented in the claims data, will increase. In order to inform qualitative analysis, segmented regression analysis will be stratified by PPS to identify those PPS's that demonstrated increases in primary care utilization and expenditures.

Issues pertaining to increasing the availability and utilization of primary care will be also be investigated using qualitative data, gathered on an annual basis. Key informant interviews with senior level PPS administrative staff will be developed and tailored to PPS's based on health care transformation project selected. The following broad questions will be addressed:

1. What barriers were encountered in increasing the number of PCP's meeting PCMH or other advanced primary care criteria?
2. What was the influence of other health care reform initiatives outside of DSRIP that may have affected efforts to increase primary care utilization and availability as part of the DSRIP health care system transformation projects?
3. How did the increasing of primary care serve to increase care efficiency such as avoiding use of the ER or inpatient/institutional care?

In addition to the CAHPS survey data which obtains patient level data, survey questions will be developed for administration to patients served under each PPS will be conducted to obtain information on primary care utilization. Questions to be addressed from a patient perspective include:

1. Are you able to see the same primary care provider each time you need a visit?
2. Are you satisfied with the distance you have to travel to see your regular primary care provider?
3. Are referrals you get from your provider conveniently located and accessible?
4. How well does your primary care provider understand your health care needs?
5. Is a primary care provider more accessible than the emergency room for minor health care needs?

Comparison Analysis

Assessing the relative impact on health transformation projects on primary care utilization and expenditures will be conducted by comparing PPS's implementing a given project to those that do not employ that project. As all projects under Domain 2 directly or indirectly affect the availability and utilization of primary care services, each will be assessed for its relative effectiveness. Difference-in-differences estimation will be used to compare change in the three outcome variables from the start of Year 1 of the demonstration through the end of year 3, controlling for PPS characteristics such as region, size (e.g., number of participating providers and Medicaid beneficiaries served), population demographics and health status, and, where possible, any other health care improvement initiatives outside of DSRIP that may be ongoing. For inclusion in the Summative Evaluation Report, overall change in outcome variables will be made between the intervention and control groups between Years 1 and 5, as well as between years 3 and 5.

In order to obtain insights on factors that may underlie success in increasing the availability and utilization of primary care, responses to both the key informant interviews and patient survey will be compared on the basis of degree of improvement from one year to the next on the pay-for-performance/pay-for-reporting metrics associated with primary care, as well as by changes in Medicaid spending on primary care. Qualitative comparisons will also be made between PPS's implementing different health care system transformation projects. These comparisons will address the following issues:

- Successes and barriers encountered with respect to increasing the number of PCP's meeting PCMH criteria.
- The influence of other health care reform initiatives outside of DSRIP affecting efforts to increase primary care utilization and availability.
- Changes in care efficiency as a function of increasing of primary care services in terms of unnecessary use of the ER or inpatient/institutional care.

Patient survey responses will also be compared by PPS, again based on degree of improvement on the primary care-related metrics and change in Medicaid spending on primary care. Comparison of patient data will focus on the following issues:

- Ability to see the same primary care provider at each visit.
- Travel distance you have to travel to see regular primary care provider.
- Degree to which referrals from primary care provider are conveniently located and accessible.
- Primary care provider understanding of patient health care needs.
- Degree to which a primary care provider is at least as accessible as the emergency room for minor health care needs.

As well as patient-level responses by PPS, patient responses will also be compared by demographics such as age, sex, and race, as well as mental health and substance abuse status, and presence of chronic diseases.

4. Availability and use of behavioral health services, and behavioral health care spending.

As a central aspect of DSRIP is to increase the use of behavioral health services and to better coordinate and integrate these services with services with primary care and other physical health services, it is hypothesized that behavioral health services utilization will increase with the introduction of DSRIP, as will Medicaid expenditures for behavioral health services. As earlier described, interrupted time series/segmented regression will be used to test this hypothesis at the statewide level. Medicaid claims data will be used to measure behavioral health care utilization and costs on these services. Inpatient, outpatient, and partial hospitalization services for behavioral health will be identified in Medicaid claims on the basis of primary diagnosis (mental illness or substance abuse), provider type, and provider location as documented on the claims or encounters. Per member per month services received for behavioral health, and per member per month expenditures for behavioral health services will be calculated as the outcome variables for the analysis. In addition to statewide analysis, the results will be stratified by PPS to identify those demonstrating improvement in this area vs. those that do not in order to inform the qualitative investigation of this issue.

Key informant interviews will be developed and conducted on an annual basis with PPS leadership staff on the expansion of behavioral health services. Questions to be addressed will include:

1. How was expansion of behavioral health incorporated into projects undertaken for health care system transformation?
2. What factors contributed to success in expanding the availability of behavioral health services through health care system transformation projects?
3. What unique challenges were associated with expanding the availability of behavioral health services?
4. What steps were taken to integrate behavioral health services with other health care services, and what were some notable achievements in this regard?
5. What effect, if any, did other health care reform initiatives affect efforts to expand behavioral health services?

Focus groups will be conducted with representative health care providers in each PPS regarding the expansion of behavioral health services as part of health care system transformation under DSRIP. Questions to be addressed from the provider perspective include:

1. What steps are taken to identify a patient's behavioral health care needs?
2. How has the provision of needed health care services improved with PPS participation?
3. What barriers still exist in getting a patient into needed behavioral health treatment?

Patient level perspectives on the availability and utilization of behavioral health care will be obtained through a patient survey administered to a sample of Medicaid beneficiaries receiving behavioral health services under each PPS.

1. How were you referred into mental health or substance abuse treatment?
2. Are the services you receive convenient in terms of location and hours available?
3. Are you able to easily obtain an appointment for mental health or substance abuse services when you need one?
4. Is your primary care provider, or other health care providers that you see, aware of you mental health or substance abuse service needs?

Comparison Analysis

To assess the differential impact of specific health care system transformation projects on the use of, and expenditures for, behavioral health services, difference-in-differences analysis will be used to compare changes in these outcomes among PPS's adopting a particular health care system transformation project vs. those that don't adopt that project. Change will be assessed from the start of Year 1 of the demonstration through the end of year 3, controlling for PPS characteristics such as region, size (e.g., number of participating providers and Medicaid beneficiaries served), population demographics and health status, and, where possible, any other health care improvement initiatives outside of DSRIP that may be ongoing. For inclusion in the Summative Evaluation Report, overall change in behavioral health services utilization and spending will be made between the intervention and control groups between Years 1 and 5, as well as between years 3 and 5.

Responses on the key informant interviews, focus groups, and patient surveys will be compared between PPS's demonstrating improvement in the provision of behavioral health services based on the quantitative analysis, vs. those that do not in order to identify programmatic strengths and weaknesses. Comparison on qualitative responses will also be made between PPS's undertaking different health care system transformation projects to contribute to the identification of those that are particularly effective,

and factors associated with particular health care system transformation strategies that result in lesser degrees of success in increasing the availability of behavioral health care. Qualitative comparisons at the levels of PPS, and health care system transformation strategy, will address the following issues:

1. Methods used to incorporate behavioral health care system transformation projects.
2. Factors contributing to success in expanding the availability of behavioral health services through health care system transformation projects.
3. Challenges associated with expanding the availability of behavioral health services.
4. Steps were taken to integrate behavioral health services with other health care services, and identification of those that were particularly effective.
5. Steps are taken to identify a patient's behavioral health care needs?
6. Remaining barriers to getting patients into needed behavioral health care treatment.
7. How patients were referred into mental health or substance abuse treatment.
8. Convenience of behavioral health services from patients' perspectives.
9. Awareness of other health care providers of patients' behavioral health service needs, from patients' perspectives.

Patient-level data will also be compared by demographics and presence of co-occurring chronic illness, both across and within PPS's.

5. Medicaid spending on emergency department and inpatient services.

Using Medicaid claims data, as shown in Table 1, the statewide impact of DSRIP on expenditures for emergency department and inpatient services, as major program outcomes, will be assessed using the interrupted time series design with segmented regression. The hypothesis to be tested is that Medicaid spending on these services will decrease following the introduction of DSRIP. Claims and encounters for these services will be identified in the database by service codes associated with the claim/encounter for both ED and inpatient services, along with the presence of admission and discharge dates, and admission diagnoses, in the case of inpatient services, with the costs associated with these claims used for the analysis. Per member per month expenditures will be calculated for both ED and inpatient services and will serve as the outcome variables in the analyses.

Comparison Analysis

Assessing the relative impact of the health care system transformation strategies on ED and inpatient services will be conducted by comparing PPS's implementing a given strategy (intervention group) to those that do not employ that strategy (control group). Difference-in-differences estimation will be used to compare change in per member per month expenditures on these two services from the start of Year 1 of the demonstration through the end of year 3, controlling for PPS characteristics such as region, size (e.g., number of participating providers and Medicaid beneficiaries served), population demographics and health status, and, where possible, any other health care improvement initiatives outside of DSRIP that may be ongoing. For inclusion in the Summative Evaluation Report, overall change in outcome variables will be made between the intervention and control groups between Years 1 and 5, as well as between years 3 and 5.

6. Access to and utilization of primary and preventative services by uninsured, non-utilizing, and low-utilizing populations.

The statewide impact of DSRIP on the utilization of services by the uninsured (UI), non-utilizing (NU), and low-utilizing (LU) populations as a program outcome will be assessed using the interrupted time series design with segmented regression. The hypotheses to be tested is that such utilization will show an increase among these populations with respect to primary care, behavioral health, and dental services following the introduction of DSRIP, and a decrease in emergency department use. Two measures of utilization, shown in Table 1, will be used to assess DSRIP's statewide impact: 1) Percent of attributed Medicaid members with no claims history for primary care and preventive services, and 2) Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims.

Change in service utilization among UI, NU, and LU populations, a project open only to eligible PPS's, will also be investigated using qualitative data, gathered on an annual basis, at the PPS level. Key informant interviews and focus group interviews with providers will be used to address questions that cannot be addressed in the quantitative analysis, as well as provide context for PPS-level quantitative results. Questions pertaining to this project are as follows:

1. What steps were taken within this PPS project to achieve project goals?
2. What were some notable successes in implementing this project?
3. What challenges or barriers were encountered in reaching out to these populations and making services available?
4. What organizational and contractual arrangements were made to implement this project?
5. What steps were taken as part of the projects to increase the availability and utilization of primary care, behavioral health, and dental services, and what challenges were encountered with respect to each of the three service types?
6. What other initiatives outside of DSRIP affected efforts to provide services to these populations, and how were those efforts affected?

Comparison Analysis

Comparisons between PPS's implementing a project to increase access to and utilization of care to UI, NU, and LU populations, and those PPS's that do not implement this project, will be made using difference-in-differences analysis. The hypothesis is that those PPS's implementing a project to engage these populations in services will show greater improvement on the four outcome measures associated with this project (Table 1) compared to those that do not implement this project. Two of the four measures are survey measures that capture patient-level data are included in the performance metrics for this project: The Patient Activation Measure (PAM), which measures patients' self-reported knowledge, skill, and confidence to self-manage his/her own health condition(s), and CG-CAHPS survey data measuring the UI experience with the health care system. While the treatment PPS's (those implementing this project) will be reporting these data on the yearly data reporting schedule (as described in the DSRIP Measure Specification and Reporting Manual⁵), a group of comparable control PPS's (PPS's not implementing this project) will be identified to collect and report these survey data, as well. For all four outcome measures (the patient surveys and the two measures based on Medicaid claims), difference-in-differences analysis will compare differences in change between treatment and controls from years 1 to 3 (for mid-point evaluation report) and from both years 3 to 5, and from years 1 to 5, for the summative report.

Among PPS’s that implement a project to increase service access and utilization among UI, NU, and LU populations, qualitative comparisons will be made on the basis of the degree improvement on the pay-for-reporting/pay-for-performance metrics as determined by the Independent Assessor. Key informant interviews with PPS planners and administrators, and focus groups with PPS providers will be conducted to obtain insights on project planning, implementation, operation, and effectiveness, and will address differences between PPS’s on the following issues:

- Steps taken as part of the projects to increase the availability and utilization of primary care, behavioral health, and dental services, and successes and challenges characteristic of each service type.
- Notable successes, and barriers encountered in implementing this project.
- Challenges or barriers encountered in reaching out to these populations to making services available and encourage use.
- Organizational and contractual arrangements made to implement this project.
- Other initiatives outside of DSRIP that may have affected efforts to provide services to these populations, and how those efforts were affected.

Table 1. System Transformation Outcome Variables and Measures			
Outcome	Measure	Data Source	Related Hypotheses
Integration of Service Delivery	Percent of eligible providers with participating agreements with RHIO’s; Percent meeting MU criteria and able to participate in bidirectional exchange	PPS Reporting	Health care service delivery will show greater integration as a result of DSRIP
Care Coordination	CAHPS Measures – Care coordination with provider up-to-date about care received from other providers	CAHPS Survey Data	DSRIP will result in improved care coordination.
	H-CAHPS – Care transition metrics	H-CAHPS Hospital Care Survey	
Availability and Use of Primary Care	Percent of PCP meeting PCMH (NCQA)/ Advanced Primary Care (SHIP) Criteria	PPS Reporting	Primary care utilization will show a greater upward trend as a result of DSRIP.
	CAHPS measures including usual source of care patient loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)	CAHPS Survey Data	
Medicaid Spending	Medicaid spending on PC and community based behavioral health care	Medicaid Claims	Use of primary care and behavioral health care, and associated Medicaid expenditures, will

			increase as a result of DSRIP.
	Medicaid spending on ER and inpatient services	Medicaid Claims	Medicaid spending on ER and inpatient services will decrease as a result of DSRIP.
Access & Utilization by UI, NU, & LU Populations	Interval Change in Patient Activation Measure® (PAM®) – Percent of members measured at Level 3 or 4 on the PAM® utilizing at least 13 item version. (Done separately for each population – UI and NU/LU)	PAM Survey	PPS’s that implement a project to engage UI, NU, and LU populations will show improvement with respect to managing own health conditions and experience with the health care system, compared to those that do not implement such a project.
	CG-CAHPS done by PPS documenting the uninsured population experience with the health care system	CG-CAHPS survey	
	Use of primary and preventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members)	Medicaid Claims	<ol style="list-style-type: none"> 1. Among UI, NU and LU populations, primary and preventive care services will increase on a statewide basis as a result of DSRIP, while emergency department services will decrease. 2. PPS’s that implement a project to engage these populations will show greater improvement on these measures than
	Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims compared to same in baseline year. (Uninsured only)	Medicaid Claims	

			those PPS's that do not.
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Question 2: Did health care quality improve as a result of clinical improvements in the treatment of selected diseases and conditions?

All DSRIP plans must include at least two projects from Domain 3, focusing on clinical improvements. PPS's must select these projects based on their community needs assessment. At least one of those projects must be a behavioral health project from sub-list A, as described below. PPS's can submit up to 4 projects from Domain 3 for valuation scoring purposes (as described in Attachment I).

A. Behavioral Health (required)

- Integration of primary care and behavioral health services
- Behavioral health community crisis stabilization services
- Implementation of evidence-based medication adherence program (MAP) in community based sites for behavioral health medication compliance
- Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs
- Behavioral Interventions Paradigm (BIP) in Nursing Homes

B. Cardiovascular Health

Note: PPS's selecting cardiovascular health projects will be expected to utilize strategies contained in the Million Hearts campaign as appropriate (<http://millionhearts.hhs.gov/index.html>).

- Evidence-based strategies for disease management in high risk/affected populations (adult only)
- Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adult only)

C. Diabetes Care

- Evidence-based strategies for disease management in high risk/affected populations (adults only)
- Implementation of evidence-based strategies in the community to address chronic disease -- primary and secondary prevention projects (adults only).

D. Asthma

- Development of evidence-based medication adherence programs (MAP) in community settings --asthma medication
- Expansion of asthma home-based self-management program
- Implementation of evidence-based medicine guidelines for asthma management

E. HIV/AIDS

- Comprehensive Strategy to decrease HIV/AIDS transmission to reduce avoidable hospitalizations -- development of a Center of Excellence for management of HIV/AIDS

F. Perinatal Care

- Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

G. Palliative Care

- Integration of palliative care into the PCMH Model
- Integration of palliative care into nursing homes

H. Renal Care

- Specialized Medical Home from Chronic Renal Failure

Using the interrupted time series/segmented regression approach, it is hypothesized that, through clinical improvements, health care quality in each of these 8 areas will show greater improvement on a statewide level over a five year period following the implementation of DSRIP as compared to a five year

period prior to the implementation of DSRIP. The outcome measures will be the same as those used for the pay-for-reporting/pay-for-performance metrics, shown in Table 2. Potentially preventable emergency room visits among those with behavioral health diagnoses, a metric under this domain, will be addressed under Objective 4 below.

Key informant and focus group interviews will be developed for PPS administrators and providers, respectively, and these data will be gathered on an annual basis. Interview questions for each PPS will be tailored to the projects selected, and will address the following broad questions:

1. What aspects or components of clinical improvement projects were particularly effective?
2. What were some of the challenges in implementing and operating a project to improve care for the identified condition?
3. What organizational or contractual arrangements were necessary to implement clinical improvement projects in the areas selected?
4. What clinical practice changes were made as part of program implementation?
5. What were notable differences between implementation of the behavioral health project and projects for other selected conditions?
6. How are efforts at implementing clinical improvements under DSRIP affected by other health care reform initiatives operating concurrently?

Patient-level survey data pertaining to Domain 3 projects will also be obtained on an annual basis. Questions will be specific to the projects implemented by the PPS's under which patients are served, and will address the following broad questions:

1. How satisfied are patients with the care they receive?
2. How accessible do patients find the care for their particular health conditions to be?
3. How well do patients feel that their health care providers are managing their condition?
4. How do patients describe their quality of life?

Comparison Analysis

For all areas except for behavioral health (which is required of all PPS's), differences-in-differences analysis will be used to compare change in the quantitative outcome variables between PPS's that selected a particular area in which to implement a project (e.g., asthma) to PPS's that do not select a project in that area. The hypothesis to be tested is that the degree of improvement in care quality, by all measures, will be greater for PPS's implementing a project in that area than for those that do not. Such analyses will control for potential differences in PPS attributed populations (e.g., age, sex, comorbidities), as well as other interventions that may be ongoing in a PPS catchment area (e.g., NYSDOH Prevention Agenda activities, Medicaid enrollment changes), where possible. Change from DY 1 through DY 3, DY 3 through DY 5, and change over the entire demonstration from DY1 through DY 5 will be assessed in these analyses. Comparisons to be made are contingent upon the final selection of PPS's and the distribution of selected clinical improvement projects.

For those areas in which there is more than one project option, difference-in-differences analysis will also be used to assess the relative effectiveness of specific projects within a given area of clinical improvement vs. alternative projects in that area. For example, within the behavioral health strategy, PPS's implementing a project to integrate primary care and behavioral health services (project 3.a.i) would be compared to PPS's implementing other behavioral health projects on the behavioral health

outcome measures. As described above, changes will be assessed from DY1 through DY 3, DY 3 through DY 5, and DY 1 through DY 5.

Within groups of PPS's that implement a project to make clinical improvements in a particular area under Domain 3, qualitative comparisons of the key informant, focus group, and patient survey data, will be made between PPS's on the basis of degree of achievement of the pay-for-reporting/pay-for-performance metrics associated with that clinical improvement area, as determined by the Independent Assessor. This will be done on an annual basis in order to obtain contextual information pertaining to successes and challenges in improving care quality for each of the 8 areas, allowing the provision of feedback to PPS's for program modification and refinement. The differences in PPS's, based on achievement of project milestones, that will be explored qualitatively include

1. Aspects or components of clinical improvement projects were particularly effective.
2. Challenges in implementing and operating a project to improve care for the identified condition, and how those challenges are specific to particular projects within each health condition category.
3. Organizational or contractual arrangements were made to implement clinical improvement projects.
4. Clinical practice changes that were made as part of program implementation.
5. The degree to which the implementation of clinical improvements under DSRIP are affected by other health care reform initiative operating concurrently, and how this differs by project with health condition category.
6. Patient satisfaction with the care they receive.
7. Perceived accessibility, on the part of patients, to care for their particular health conditions.
8. How well patients feel that their health care providers are managing their condition.
9. How patients with the conditions under Domain 3 describe their quality of life.

Comparisons in patient-level responses (6-9 above) will also be made based on demographics (age, sex, race/ethnicity), and on the presence of other health conditions that may co-occur with the one in question.

Outcome	Measure Name	Source	Related Hypotheses
Behavioral Health	Antidepressant Medication Management	Claims	1. On a statewide level, care quality in these 8 areas will improve as a result of DSRIP. 2. PPS's that implement a project to address a given condition will
	Diabetes Monitoring for People with Diabetes and Schizophrenia	Claims	
	Diabetes Screening for People with Schizophrenia/BPD Using Antipsychotic Med.	Claims	
	Cardiovascular Monitoring for People with CVD and Schizophrenia	Claims	
	Follow-up care for Children Prescribed ADHD Medications	Claims	
	Follow-up after Hospitalization for Mental Illness	Claims	

	Screening for Clinical Depression and Follow-up	Medical Record
	Adherence to Antipsychotic Medications for People with Schizophrenia	Claims
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Claims
	PPR for SNF patients	Claims
	Percent of Long Stay Residents who have Depressive Symptoms	MDS 3.0
Cardiovascular Disease	PQI # 13 (Angina without procedure)	Claims
	Cholesterol Management for Patients with CV Conditions	Medical Record
	Controlling High Blood Pressure (Provider responsible for medical record reporting)	Medical Record
	Aspirin Discussion and Use	BRFSS
	Medical Assistance with Smoking Cessation	BRFSS
	Flu Shots for Adults Ages 50 – 64	BRFSS
	Health Literacy Items (Includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	BRFSS
Diabetes	PQI # 3 (DM long term complications)	Claims
	Comprehensive Diabetes Screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	Medical Record
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medical Record
	Comprehensive Diabetes Care - LDL-c Control (<100mg/dL)	Medical Record
	Flu Shots for Adults Ages 50 – 64	BRFSS
	Health Literacy Items (Includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	BRFSS
Asthma	PQI # 15 Adult Asthma	Claims
	PDI # 14 Pediatric Asthma	Claims
	Asthma Medication Ratio	Claims
	Medication Management for People with Asthma	Claims

show greater improvement in that area than those that do not.

HIV/AIDS	HIV/AIDS Comprehensive Care : Engaged in Care	Claims
	HIV/AIDS Comprehensive Care : Viral Load Monitoring	Claims
	HIV/AIDS Comprehensive Care : Syphilis Screening	Claims
	Cervical Cancer Screening	Claims
	Chlamydia Screening	Claims
	Medical Assistance with Smoking Cessation	BRFSS
	Viral Load Suppression	Medical Record
Perinatal Care	PQI # 9 Low Birth Weight	Claims
	Prenatal and Postpartum Care—Timeliness and Postpartum Visits	Medical Record
	Frequency of Ongoing Prenatal Care	Medical Record
	Well Care Visits in the first 15 months	Claims
	Childhood Immunization Status	Medical Record
	Lead Screening in Children	Medical Record
	PC-01 Early Elective Deliveries	Vital Records
Palliative Care	Risk-adjusted percentage of members who remained stable or demonstrated improvement in pain.	UAS
	Risk-adjusted percentage of members who had severe or more intense daily pain	UAS
	Risk-adjusted percentage of members whose pain was not controlled.	UAS
	Advanced Directives – Talked about Appointing for Health Decisions	UAS
	Depressive Feelings - percentage of members who experienced some depression feeling	UAS
Renal Care	Comprehensive Diabetes Screening (HbA1c, lipid profile, dilated eye exam, nephropathy)	Medical Record
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medical Record
	Comprehensive Diabetes Care - LDL-c control (<100mg/dL)	Medical Record

	Annual Monitoring for Patients on Persistent Medications – ACE/ARB	Claims
	Controlling High Blood Pressure	Medical Record
	Flu Vaccine 18-64	
	Medical Assistance with Smoking and Tobacco Use Cessation	

Question 3: Did population health improve as a result of implementation of the DSRIP initiative?

All DSRIP plans must include at least one project intended to improve population health (Domain 4), based on their community needs assessment. PPS’s can submit up to 2 projects from Domain 4 for valuation scoring purposes (as described in Attachment I). The available projects are categorized into four areas as follows:

A. Promote Mental Health and Prevent Substance Abuse (MHSA)

- Promote mental, emotional and behavioral (MEB) well-being in communities
- Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
- Strengthen Mental Health and Substance Abuse Infrastructure across Systems

B. Prevent Chronic Diseases

- Promote tobacco use cessation, especially among low SES populations and those with poor mental health
- Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3., such as cancer)

C. Prevent HIV and STDs

- Decrease HIV morbidity
- Increase early access to, and retention in, HIV care
- Decrease STD morbidity
- Decrease HIV and STD disparities

D. Promote Healthy Women, Infants and Children

- Reduce premature births

The statewide impact of DSRIP on population health as a key DSRIP outcome will be assessed using the interrupted time series design with segmented regression, as previously discussed. The hypothesis to be tested is that population health, according to Domain 4 measures, will show a pattern of increase following the introduction of DSRIP as compared to pre-implementation. The measures of population health associated with each project area are shown in Table 3 (four of the measures listed are applicable to all projects under this Domain), and will serve as the outcome variables in the analyses. Also, as shown in Table 3, racial and ethnic disparities will be addressed with respect to the following metrics: premature deaths, newly diagnosed cases of HIV, preterm births, adolescent pregnancy rate per 1,000

females aged 15-17, percentage of unintended pregnancy among live births, and infants exclusively breastfed while in the hospital. Disparities on these outcomes will be measured as ratios that make comparisons based on race/ethnicity. These ratios will be treated as additional outcomes at the statewide level with the prediction that these ratios will show improvement (i.e., will be reduced) following DSRIP implementation.

The key informant interviews with PPS planners and administrators which will be developed and conducted on an annual basis, will include questions pertaining to the Domain 4 projects. Questions to be addressed qualitatively include:

1. What major organizational steps were required to implement a project to improve health in the PPS population?
2. What PPS infrastructure was put into place to address population health?
3. What successes and challenges were encountered in implementing a project to improve health in the PPS population?
4. What characteristics of PPS's were contributing factors to successes of chosen projects?
5. How did the New York Prevention Agenda influence project implementation and operation?
6. What other health care reform initiatives outside of DSRIP affected the planning and implementation of the PPS Domain 4 project, and how?
7. What types of outreach efforts were needed to make health improvements at the population level, and what barriers, if any, were encountered?

Comparison Analysis

To assess the effect of the specific population health improvement strategies (project categories A-D above), difference-in-differences analysis will be used to compare change in the outcome measures between PPS's adopting a particular strategy to those that do not choose that strategy. For example, the change in age-adjusted percentage of adults with poor mental health for 14 or more days in the last month one comparison would be compared between PPS's that choose to implement a project to promote mental health and prevent substance abuse, and those that do not implement a project under this strategy. Over all, it is hypothesized that PPS's that adopt a particular population health improvement strategy will show greater improvement on the associated metrics than PPS's that do not adopt that strategy.

For those population health improvement strategies where there is more than one project option, difference-in-differences analysis will also be used to assess the relative effectiveness of specific projects within a strategy vs. alternative project options. For example, among PPS's implementing a project to promote mental health and prevent substance abuse, change in the associated outcome measures will be compared between those PPS's that implement a project to strengthen mental health and substance abuse infrastructure across systems (project 4.a.iii), and those PPS's choosing one of the other two alternative projects. Changes will be again be assessed from DY 1 through DY 3, DY 3 through DY 5, and DY 1 through DY 5.

Qualitative comparisons of responses to the key informant interviews will be made between PPS's that adopt different population health strategies, as well as between PPS's that adopt different projects within the same strategy. Such comparisons will facilitate the identification of particularly successful or challenging program elements that are characteristic of specific strategies or projects. Issues on which comparisons will focus include:

1. Organizational or contractual measures that were required for project implementation.
2. Notable successes and challenges that were encountered in implementing a project to improve health in the PPS attributed population.
3. The influence of the New York Prevention Agenda and other health care reforms outside of DSRIP on PPS efforts to improve population health.
4. Types of outreach efforts, or other means to reach population members that were used to make health improvements, and any barriers encountered.

Table 3. Population-Wide Variables and Measures

Outcome	Measure Name	Data Source	Related Hypotheses
Improve Health Status and Reduce Health Disparities (required for all projects)	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics	<p>1. Population health measures in the areas of mental health and substance abuse, prevention of chronic disease, prevention of HIV and STD's, and the health of women, infants, and children, will show improvements on a statewide level as a result of DSRIP.</p> <p>2. PPS's that adopt a particular population health strategy (e.g., mental health and substance abuse) will show greater improvement in that area than those PPS's that do not.</p>
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>		
	<i>Ratio of Hispanics to White non-Hispanics</i>		
	Percentage of adults with health insurance - Aged 18-64 years	US Census	
	Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	BRFSS	
Prevent Chronic Diseases	Percentage of adults who are obese	BRFSS	
	Percentage of children and adolescents who are obese	BRFSS	
	Percentage of cigarette smoking among adults	BRFSS	
	Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	BRFSS	
	Asthma emergency department visit rate per 10,000	SPARCS	
	Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS	

	Age-adjusted heart attack hospitalization rate per 10,000	SPARCS
	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS
	Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	SPARCS
Prevent HIV/STDs	Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System
	<i>Difference in rates (Black and White) of new HIV diagnoses</i>	
	<i>Difference in rates (Hispanic and White) of new HIV diagnoses</i>	
	Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System
		Surveillance System
	Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System
	Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System
	Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance System
	Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System
Promote Healthy Women, Infants, and Children	Percentage of preterm births	NYS NYSDOH Vital Statistics
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	<i>Ratio of Medicaid births to non-Medicaid births</i>	

	Percentage of infants exclusively breastfed in the hospital	NYS NYSDOH Vital Statistics
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	<i>Ratio of Medicaid births to non-Medicaid births</i>	
	Maternal mortality rate per 100,000 births	NYS NYSDOH Vital Statistics
	Percentage of children with any kind of health insurance - Aged under 19 years	U.S. Census Bureau, Small Area Health Insurance Estimates
	Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	NYS NYSDOH Vital Statistics
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	Percentage of unintended pregnancy among live births	Pregnancy Risk Assessment Monitoring System
	<i>Ratio of Black non-Hispanics to White non-Hispanics</i>	
	<i>Ratio of Hispanics to White non-Hispanics</i>	
	<i>Ratio of Medicaid births to non-Medicaid births</i>	
	Percentage of women with health coverage - Aged 18-64 years	U.S. Census Bureau Small Area Health Insurance Estimates
	Percentage of live births that occur within 24 months of a previous pregnancy	NYS NYSDOH Vital Statistics
Promote Mental Health and Prevention	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS

Substance Abuse		
	Age-adjusted percentage of adult binge drinking during the past month	BRFSS
	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics

Question 4: Was Avoidable Hospital Use Reduced as a Result of DSRIP?

The goal of reducing avoidable hospital use is central to the DSRIP initiative, and is an expected result of the combined efforts under DSRIP to transform the health care system, implement clinical improvements, and improve population-wide health. Using the interrupted time series/segmented regression on a statewide level, it is hypothesized that, compared to pre-DSRIP implementation, avoidable hospital use will be reduced following the implementation of DSRIP on four established measures (Domain 2 metrics):

- Potentially preventable ER visits.
- Potentially preventable hospital readmissions.
- Potentially preventable hospitalizations for ambulatory care sensitive conditions (PQI composite measure).
- Potentially preventable hospitalizations for ambulatory care sensitive conditions-Pediatric (PDI composite measure).

Using Medicaid and Medicare (in the case of those dually eligible) claims data, measures will be calculated as the number of events on a per member per month basis (PMPM) in three month intervals over five years prior to the implementation of DSRIP. Given that reduced hospital use is in large part dependent on the shorter term DSRIP achievements of health care system transformation, clinical improvements, and improvements in population health, it is anticipated that DSRIP effects on avoidable hospital use would be delayed, i.e., some amount of time would pass following the implementation of DSRIP before reductions in avoidable hospital use would be observed. One way to account for lagged effects in segmented regression analysis is to exclude outcome measurement points during the expected delay period.¹⁶ Adopting this approach, and estimating six months of DSRIP implementation before reductions in avoidable hospital use would be observed, the three-month observation would be omitted, and the first post-DSRIP PMPM measurement of avoidable hospital use on each of the four measures would be taken nine months following the implementation of DSRIP (capturing avoidable hospital usage over the previous three months). PMPM avoidable hospital visits will continue to be measured in three months intervals from that point forward.

Qualitative data will also be used to obtain insights into PPS efforts to reduce avoidable hospital use through their DSRIP projects. Key informant and focus group interview data, collected on an annual basis, will be used to obtain the perspectives of PPS administrators and providers, respectively, on projects and project components that contributed to reducing avoidable hospital use. Interview questions will be developed to address the following questions:

1. Which PPS projects had the most, and least, impact on reducing avoidable hospital use, and why?
2. What beneficiary sub-groups were the most, and least, difficult to divert from unnecessary hospital use, and why?
3. In what types of avoidable hospital use (e.g., potentially preventable ER visits, potentially preventable hospital readmissions) were reductions most easily achieved, and why?
4. In what types of avoidable hospital use were reductions most difficult to achieve, and why?
5. What PPS organizational and/or contractual characteristics had the most influence, positive or negative, on ability to reduce avoidable hospital use?
6. What were some notable successes and challenges in reducing avoidable hospital use, and what were the associated program characteristics?

7. What health care reform initiatives, outside of DSRIP, positively or negatively influenced PPS efforts to reduce avoidable hospital use through their selected projects?

Comparison Analysis

The differential impact of selected DSRIP strategies on the measures of avoidable hospital use will be assessed using difference-in-differences analysis. Under Domain 2, with which the avoidable hospital use measures are aligned, variation between PPS's is expected on the adoption of three of the four strategies (as one of the strategies, creation of integrated delivery system, is required): Implementation of Care Coordination and Transitional Care Programs, Connecting Settings, and Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations. Groups of PPS's that adopt a project under each of these three strategies will be compared to those that do not adopt that particular strategy, with respect to degree of change on the avoidable hospital use measures. For example, change in avoidable hospital use between PPS's that implement a project under the Implementation of Care Coordination and Transitional Care Programs strategy will be compared to such change among PPS's that do not. These analyses will control for differences in PPS characteristics such as region, demographic composition, and prevalence of chronic conditions, including mental illness and substance abuse, among the PPS attributed populations. The Domain 3 (Clinical Improvement) and 4 (Population-Wide Health) strategies that PPS's adopt may also have differential effects on avoidable hospital use. To the extent that data will support such comparisons, PPS's that implement a particular strategy under Domain 3 or 4 (e.g., Diabetes Care or Prevention of Chronic Disease, respectively) will be compared to PPS's that do not adopt a project under that strategy with respect to change in the four measures of avoidable hospital use. Change will be assessed from DY1 through DY 3, DY 3 through DY 5, and DY 1 through DY 5.

Projects under two DSRIP strategies are required of all PPS's: Creating an Integrated Delivery System (Domain 2), and Behavioral Health (Domain 3). Given that a project under these two strategies is required of all PPS's, it is anticipated that data will support project-level comparisons within these strategies to assess the differential impact on avoidable hospital use of the projects within these strategies. Difference-in-differences analysis will be used to compare PPS's that implement a particular project (e.g., integration of primary care and behavioral health services, a project option under the Behavioral Health strategy in Domain 3) with those PPS's that do not adopt that project with respect to change in avoidable hospital use. Again, changes will be assessed from DY1 through DY 3, DY 3 through DY 5, and DY 1 through DY 5.

Key informant interview and provider focus group data pertaining to avoidable hospital use will be compared between PPS's. These comparisons will be based on the degree to which pay-for-reporting/pay-for-performance milestones were achieved on the 4 avoidable hospital use metrics. Those PPS's achieving, or making significant progress toward achieving, these milestones (as determined by the Independent Assessor), will be compared to those PPS's making lesser degrees of improvement with respect to the following issues:

1. PPS strategies and projects that were most effective in reducing avoidable hospital use, and how.
2. The types of avoidable hospital use (e.g., potentially preventable ER visits, potentially preventable hospital readmissions) that were reductions most easily achieved, and why?
3. The types of avoidable hospital use were reductions most difficult to achieve, and why.

4. PPS organizational and/or contractual characteristics that influence PPS success or failure to avoid unnecessary hospital use.
5. Health care reform initiatives, outside of DSRIP, that may have positively or negatively influenced PPS efforts to reduce avoidable hospital use through their selected projects.

Question 5: Did DSRIP reduce health care costs?

Consistent with the MRT Triple Aim of better care, better health, and at lower cost, a goal of the DSRIP initiative is to reduce Medicaid expenditures. With the implementation of DSRIP, Medicaid health care expenditures may be reduced through payment reform based on positive health outcomes, as opposed to services delivered, as well as through reductions in avoidable hospital use.

It is therefore predicted that, on a statewide level using the interrupted time series/segmented regression analysis, slowed growth or reduction of Medicaid expenditures will be demonstrated for two cost outcomes following the implementation of DSRIP: 1) hospital inpatient and ED services, and 2) total cost of care.

Using Medicaid claims data, total hospital expenditures, as well as total health care expenditures under Medicaid (including both capitation and fee-for-service), will be calculated on a PMPM basis in three month intervals over five years prior to the implementation of DSRIP. Reduction in total health care expenditures under Medicaid, as well as reduction in costs associated with avoidable hospital use, are longer-term outcomes, dependent upon shorter term DSRIP health care improvements, including health care system transformations and clinical improvements. Given the expected lag in the effect of DSRIP on hospital-associated and total Medicaid expenditures, post-DSRIP measurement points will be handled in the same manner as described above for avoidable hospital use, with the first post-DSRIP PMPM calculation of hospital-associated and total Medicaid expenditures taken nine months following the implementation of DSRIP, capturing the expenditures over the previous 3 months. PMPM hospital-associated and total Medicaid expenditures will continue to be measured in three months intervals for five years from that point forward.

Question 6. Was DSRIP cost effective in terms of New York State and Federal governments receiving adequate value for their investments?

Assessment of the effect of DSRIP on health care cost will also include an analysis of cost effectiveness^{17,18} with respect to the goal of reducing avoidable hospital use, as this outcome is central to the DSRIP initiative. The intention of these analyses are to address the question of whether New York State and Federal governments are receiving adequate value for additional expenditures. Such expenditures include incentive payments to PPS's that are linked to achievement of their metrics and milestones, Design Grant funds which were available to emerging PPS's to develop their project plans, Interim Access Assurance Funds (IAAF) to allow safety net, public, critical access, and sole community hospitals at risk of closure to continue operations until a DSRIP application is submitted, approved, and funded, funding for increases in services such as primary care and behavioral health care, and additional staffing at the state level to operate DSRIP. These additional expenditures will be weighed against reduction in avoidable hospital use, in a comparison of avoidable hospital use and total costs before and after the implantation of DSRIP. Cost-effectiveness ratios, or CER's (change in cost divided by the change in outcome) will be used to express the dollar amount per unit reduction in avoidable hospital use. This information will then be compared to the average cost of an avoidable hospital use event (e.g., an avoidable hospital admission) to determine if additional expenditures incurred under DSRIP (e.g.,

incentive payments) are offset by savings through avoidable hospital use. This analysis will be conducted on all four measures of avoidable hospital use. Other analyses around cost effectiveness that may be useful would be to compare the additional expenditures specifically associated with increased primary care use to reduction in the costs of avoidable hospital use, and to compare DSRIP cost effectiveness among beneficiary subgroups, e.g., cost effectiveness comparisons across Medicaid recipients' health status, including mental health and substance abuse status.

Questions 7: What were the successes and challenges with respect to PPS planning, implementation, operation, and plans for program sustainability from the perspectives of DSRIP planners, administrators, and providers, and why were they successful or challenging?

In order to make program modifications and refinements in the DSRIP demonstration, as well as to document lessons learned to inform future endeavors of this nature, qualitative methods will be used in a case study evaluation of each PPS to investigate the processes and coalitions put into place for PPS operation, and successes and challenges associated with implementing and operating their DSRIP projects. Data gathered for Demonstration Years 1 and 2 will focus on questions around PPS and DOH experiences with DSRIP's planning and implementation, while Demonstration Years 3-5 will focus on DSRIP's operation and effectiveness.

Key informant interviews with planners and administrators and focus groups with providers will be the primary methods used to obtain this information. DSRIP planning documents and program materials will be reviewed, as available, as sources of background information.

Planning and Implementation. During the planning and implementation stages of the DSRIP initiative, stakeholder feedback will be gathered regarding the following questions:

- What positive outcomes are expected as the result of DSRIP?
- What difficulties were encountered in getting a PPS approved?
- What additional information would have been helpful in the application process?
- What factors were considered in PPS's choosing particular projects, e.g., local factors, evidence of community need, operational feasibility?
- What were some obstacles in organizing coalitions between providers participating in a PPS?
- What difficulties were encountered in developing and implementing a PPS?
- What difficulties were encountered in implementing specific projects?
- Which system transformation strategies were the most challenging to implement and how might that affect outcomes?
- What were the notable barriers to integrating and coordinating care?
- How was rapid-cycle evaluation used in developing PPS projects?
- How did the learning collaboratives support system change?
- What were some of the earliest improvements in health care delivery that were made as a result of DSRIP?
- What difficulties were encountered in gathering the necessary data about the PPS?
- How was DSRIP initially received by the community?
- Which system transformation strategies were the most challenging to implement, and why, and how might that affect outcomes?
- For which strategies were the fewest challenges encountered?
- What were the notable barriers to integrating and coordinating care?

- What successes and challenges were encountered by PPS's in implementing the attribution methodology?
- What difficulties were encountered in reaching the attributed population?
- What health care reform initiatives outside of DSRIP affected planning and implementation of DSRIP projects?

DSRIP Operation. Qualitative analysis for the operational stage of the DSRIP initiative will emphasize program functioning and outcomes as perceived by program planners, administrators, and providers. The broad questions to be addressed include:

- What care improvements have been most notable?
- Which sub-populations saw the most improvement?
- What difficulties were encountered in operating a PPS?
- Which implemented strategies were the most challenging to implement and how did that affect outcomes?
- What processes were put into place to maintain and track the PPS attributed population, and what successes and challenges were encountered?
- How were coalitions put into place for PPS operation maintained?
- What complications or barriers were encountered in maintaining the coalitions that were formed?
- For which strategies were the fewest challenges encountered?
- What were the notable partnerships that were formed in implementing a PPS?
- How was the PPS received by the community?
- What intended PPS goals were not achieved, and why?
- What were the notable barriers to integrating and coordinating care?
- What difficulties were encountered in reaching the service population?
- What clinical improvement and population health strategies were the most and least effective and why?
- What strategies were the most, or least, successful in reducing avoidable hospital use, and why?
- What health care reform initiatives outside of DSRIP affected PPS operation, and how?

Comparison Analysis

In order to identify key concepts and themes in PPS planning, implementation, and operation that may be common to particular strategies and projects, comparisons will be made between PPS's based on this basis. PPS comparisons by region (e.g., urban vs. rural, New York City vs. Rest of State) will be made to identify those concepts and themes that may be characteristic of the geographic areas that PPS's serve.

III. Data Sources

Addressing the evaluation questions will involve the use of a number of existing data sources that are maintained by, or are available to, the New York State Department of Health. Given public health law and/or data use agreements that govern access to these data, bidders for the Independent Evaluator should be aware that obtaining access may require substantial time and effort, which should be considered when developing the evaluation timeline.

Medicaid Claims

This database contains billing records for health care services, including pharmacy, for approximately 5.7 million individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid claims database is updated on a monthly basis to include additional claims and modifications to existing claims. Given the claims processing, there is a 6-month lag in the availability of complete and finalized Medicaid claims data, where data for a given year are considered final by June 30th of the following year.

Medicare Claims

For the approximately 15% of Medicaid enrollees who are dually eligible for Medicare, Medicare claims will be used to ensure data completeness, as many of the services received by this group will be paid by Medicare and thus not appear in the Medicaid database. Medicare claims contains billing records for health care services, including pharmacy services, along with data on diagnoses and provider information. NYSDOH is working with an external entity specializing in the linking of Medicaid and Medicare claims data under a Coordination of Benefits Agreement (COBA), which will ensure timely access to Medicare claims through monthly data updates.

Statewide Planning and Research Cooperative System (SPARCS)

The Statewide Planning and Research Cooperative System (SPARCS) is an all payer data reporting system established in 1979 as a result of cooperation between the health care industry and government. Initially created to collect information on discharges from hospitals, SPARCS currently collects patient level detail on patient characteristics, diagnoses and treatments, services, and charges for inpatient and outpatient (ambulatory surgery, emergency department, and outpatient services), hospital services and outpatient services from free-standing ambulatory surgery centers. SPARCS data may be used for medical or scientific research or statistical or epidemiological purposes. All entities seeking SPARCS identifiable or limited data must submit a request to SPARCS Operations using standard data request forms. Finalized SPARCS data for a given year are available in August of the following year.

Minimum Data Set (MDS)

MDS 2.0 and 3.0 data consist of federally mandated assessments collected at regular intervals on all nursing home residents in New York. Assessment data collected include diseases and conditions, nutritional status, resident physical and cognitive functioning (e.g., activities of daily living), medications received, and nursing home admission source and discharge disposition. These data have been shown to be adequately reliable and are widely used in research, and are available to the New York Department of Health under data use agreement with CMS. There is, approximately, a 6-month lag in the availability of complete MDS data, where finalized data for a given year are available in June of the following year.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The Clinician & Group version of the CAHPS® survey will be administered by NYSDOH annually during the DSRIP demonstration period and will serve as the data source for selected outcome measures. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and office staff. This includes information on patient experience over the last twelve months including most recent visit to provider, ease of getting an appointment, and wait times while in the office. The survey includes standardized questionnaires for adults and children. The adult questionnaire can be used in both primary care and specialty care settings; the child questionnaire is designed for primary care settings, but could be adapted for specialty care. Users can also add supplemental items to customize their questionnaires. Surveys are administered in September of a given year, and are

available for use in February of the following year. Given confidentiality agreements, only de-identified CAHPS data will be available for use.

New York Vital Statistics

Birth and death certificate data are maintained by New York, with New York City Department of Health and Mental Hygiene and the New York Department of Health comprising two separate jurisdictions in the reporting of birth and death records, which will likely necessitate separate data use agreements. NYSDOH has the responsibility for annual statewide reporting of vital statistics governed by the terms of a memorandum of understanding between the two jurisdictions. Birth records contain information such as maternal medical risk factors, prenatal care received, infant birth date, birth weight, and infant diseases/conditions including congenital malformations. Death certificate data include date of death, underlying and multiple cause of death, decedent demographics, county of residence, and county of death. While Vital Statistics data are received by NYSDOH on an ongoing basis, due to the process of updating and finalizing information from birth and death certificates (e.g., due to delayed receipt of lab results), data for a given year are not considered complete until the end of the following year.

Expanded Behavioral Risk Factor Surveillance System (eBRFSS)

The Expanded Risk Factor Surveillance System (Expanded BRFSS) augments the CDC Behavioral Risk Factor Surveillance System (BRFSS), which is conducted annually in New York. Expanded BRFSS is a random-digit-dialed telephone survey among adults 18 years of age and older representative of the non-institutionalized civilian population with landline telephones or cell phones living in New York. The goal of Expanded BRFSS is to collect county-specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. Topics assessed by the Expanded BRFSS include tobacco use, physical inactivity, diet, use of cancer screening services, and other factors linked to the leading causes of morbidity and mortality. The 2013-2014 eBRFSS survey will be used as the baseline for DSRIP for measures derived from these data, and contains a question to identify Medicaid respondents. Repeat eBRFSS surveys to be used in support of the DSRIP evaluation will be conducted in 2016-2017, and again in 2019-2020.

New York HIV/AIDS Case Surveillance Registry

The New York HIV/AIDS Case Surveillance Registry contains information on new cases of HIV and AIDS, as well as persons living with HIV or AIDS. Data include date of diagnosis, HIV exposure category, county of residence at diagnosis, and whether or not diagnosis was made while individual was incarcerated.

Uniform Assessment System (UAS)

The Uniform Assessment System contains assessment data on individuals receiving home or community-based long term care (e.g., adult day health care, long term home health care). Data include patient functional status, health status, cognitive functioning, and care preferences.

US Census

US census data are publicly available from the US Census Bureau, and contain estimates of population size, and data on population characteristics. The latter include housing status, income, employment status, educational level, and health insurance coverage. US census data are gathered on an ongoing basis from a number of surveys including the Decennial Census, the American Community Survey, and the Economic Census.

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ATTACHMENT L

Appendix H

for CONTRACTOR that creates, receives, maintains or transmits individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

- VII. Definitions. For purposes of this Appendix H of this AGREEMENT:
- A. “Business Associate” shall mean CONTRACTOR.
 - B. “Covered Program” shall mean the STATE.
 - C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and implementing regulations, including those at 45 CFR Parts 160 and 164.
- VIII. Obligations and Activities of Business Associate:
- A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.
 - B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT and to comply with the security standards for the protection of electronic protected health information in 45 CFR Part 164, Subpart C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.
 - C. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:
 - 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 - 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
 - 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 - 4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
 - 5. Contact procedures for Covered Program to ask questions or learn additional information.
 - D. Business Associate agrees, in accordance with 45 CFR § 164.502(e)(1)(ii), to ensure that any Subcontractors that create, receive, maintain, or transmit Protected

Health Information on behalf of the Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.

- E. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.
 - F. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.
 - G. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528; and Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.
 - H. Business Associate agrees, to the extent the Business Associate is to carry out Covered Program's obligation under 45 CFR Part 164, Subpart E, to comply with the requirements of 45 CFR Part 164, Subpart E that apply to Covered Program in the performance of such obligation.
 - I. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- IX. Permitted Uses and Disclosures by Business Associate
- A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.
 - B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.
 - C. Business Associate may disclose Protected Health Information as Required By Law.
- X. Term and Termination
- A. This AGREEMENT shall be effective for the term as specified on the cover page of this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected

Health Information, protections are extended to such information, in accordance with the termination provisions in this Appendix H of this AGREEMENT.

- B. Termination for Cause. Upon Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.
- C. Effect of Termination.
 - 1. Except as provided in paragraph (c)(2) below, upon termination of this AGREEMENT, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Program, or created or received by Business Associate on behalf of Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - 2. In the event that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of Business Associate and Covered Program that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this AGREEMENT to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

XI. Violations

- A. Any violation of this AGREEMENT may cause irreparable harm to the STATE. Therefore, the STATE may seek any legal remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.
- B. Business Associate shall indemnify and hold the STATE harmless against all claims and costs resulting from acts/omissions of Business Associate in connection with Business Associate's obligations under this AGREEMENT. Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the STATE from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law § 208, caused by any intentional act or negligence of Business Associate, its agents, employees, partners or subcontractors, without limitation; provided, however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

XII. Miscellaneous

- A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.
- B. Amendment. Business Associate and Covered Program agree to take such action as is necessary to amend this AGREEMENT from time to time as is necessary for Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and 164.
- C. Survival. The respective rights and obligations of Business Associate under (IV)(C) of this Appendix H of this AGREEMENT shall survive the termination of this AGREEMENT.
- D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

ATTACHMENT L

Appendix H

for CONTRACTOR that creates, receives, maintains or transmits individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

XIII. Definitions. For purposes of this Appendix H of this AGREEMENT:

- A. “Business Associate” shall mean CONTRACTOR.
- B. “Covered Program” shall mean the STATE.
- C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and implementing regulations, including those at 45 CFR Parts 160 and 164.

XIV. Obligations and Activities of Business Associate:

- A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.
- B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT and to comply with the security standards for the protection of electronic protected health information in 45 CFR Part 164, Subpart C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.
- C. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:
 - 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 - 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
 - 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 - 4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
 - 5. Contact procedures for Covered Program to ask questions or learn additional information.
- D. Business Associate agrees, in accordance with 45 CFR § 164.502(e)(1)(ii), to ensure that any Subcontractors that create, receive, maintain, or transmit Protected

Health Information on behalf of the Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.

- E. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.
 - F. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.
 - G. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528; and Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.
 - H. Business Associate agrees, to the extent the Business Associate is to carry out Covered Program's obligation under 45 CFR Part 164, Subpart E, to comply with the requirements of 45 CFR Part 164, Subpart E that apply to Covered Program in the performance of such obligation.
 - I. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- XV. Permitted Uses and Disclosures by Business Associate
- A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.
 - B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.
 - C. Business Associate may disclose Protected Health Information as Required By Law.
- XVI. Term and Termination
- A. This AGREEMENT shall be effective for the term as specified on the cover page of this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected

Health Information, protections are extended to such information, in accordance with the termination provisions in this Appendix H of this AGREEMENT.

- B. Termination for Cause. Upon Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.
- C. Effect of Termination.
 - 1. Except as provided in paragraph (c)(2) below, upon termination of this AGREEMENT, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Program, or created or received by Business Associate on behalf of Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - 2. In the event that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of Business Associate and Covered Program that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this AGREEMENT to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

XVII. Violations

- A. Any violation of this AGREEMENT may cause irreparable harm to the STATE. Therefore, the STATE may seek any legal remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.
- B. Business Associate shall indemnify and hold the STATE harmless against all claims and costs resulting from acts/omissions of Business Associate in connection with Business Associate's obligations under this AGREEMENT. Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the STATE from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law § 208, caused by any intentional act or negligence of Business Associate, its agents, employees, partners or subcontractors, without limitation; provided, however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

XVIII. Miscellaneous

- A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.
- B. Amendment. Business Associate and Covered Program agree to take such action as is necessary to amend this AGREEMENT from time to time as is necessary for Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and 164.
- C. Survival. The respective rights and obligations of Business Associate under (IV)(C) of this Appendix H of this AGREEMENT shall survive the termination of this AGREEMENT.
- D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.